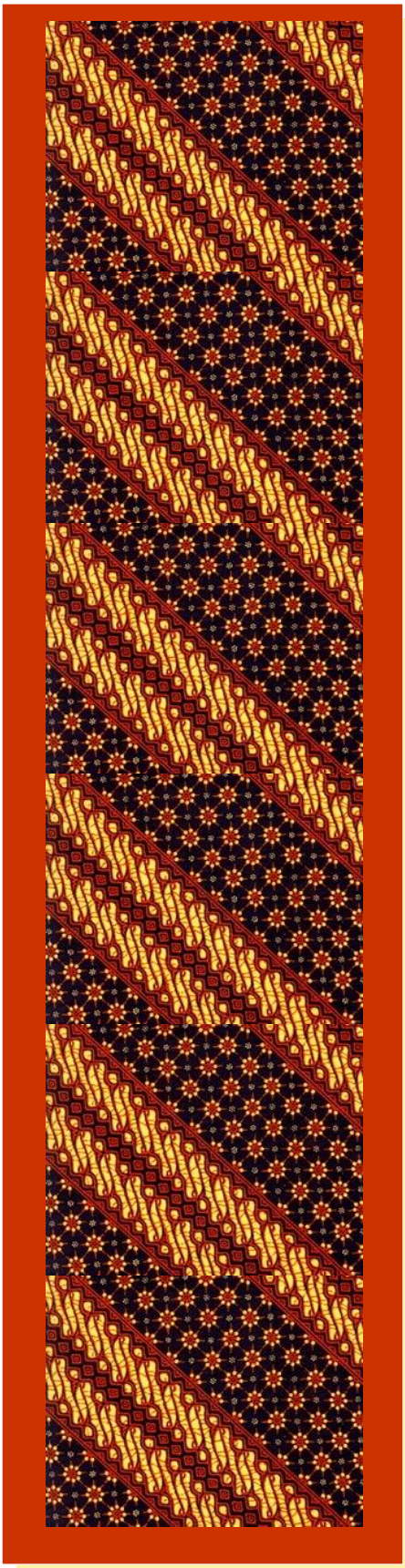
USAID FROM THE AMERICAN PEOPLE | SCALING UP FOR MOST-AT-RISK POPULATIONS



SUPPORTING THE HIV RESPONSE:

A MANUAL FOR CIVIL SOCIETY ORGANIZATIONS

TRANSGENDER PERSONS

April 2011

FHI/SUM I Task Order No. GHH-I-00-07-00043-00

TRG/SUM II Task Order No. GHH-I-03-07-00070-00

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Table of Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ATS	Amphetamine-type stimulants
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
CBO	Community-based organization
CITC	Client-initiated HIV Testing and Counseling
CSO	Civil society organization
DiCs	Drop-in Centers
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV Counseling and Testing
HRPP	Human resources policies and procedures
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological-Behavioral Surveillance
IDU	Injecting drug user/person who injects drugs
IEC	Information, education, communication
KPA	Indonesian National AIDS Commission
MARP	Most At Risk Population
M&E	Monitoring and Evaluation
MMT	Methadone maintenance therapy
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-government organization
NSP	Needle and Syringe Program
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PITC	Provider-initiated HIV Testing and Counseling
PLHIV	Person/people living with HIV or AIDS
PPT	Periodic Presumptive Treatment
PSE	Population size estimation
RETA	Resource Estimation Tool for Advocacy
RNM	Resource Needs Model
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USPSTF	U.S. Preventive Services Task Force
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Purpose of this Manual

Introduction

The primary purpose of this manual is to strengthen the engagement of civil society organizations (CSOs) in the HIV response. The focus on *engagement* underscores the need for multiple partners and stakeholders to engage collaboratively together if the response to HIV, ultimately, is to be successful. So while the guidelines and best practices in the manual are centered on the CSO role and standards of quality – in organizational performance and technical capacity – they are provided within the larger context of partnership and stakeholder engagement in a district-wide HIV response.

Networking and building partnerships are critical leadership functions and as such are underlying themes throughout this manual. They are especially critical in bringing collective leadership to the district-level HIV response, in mobilizing the HIV response, and in advocacy efforts.

This manual for CSOs working with female sex workers (FSW) is one of four manuals prepared by the USAID Scaling Up for Most-at-Risk Populations (SUM) Program. The three additional manuals are for civil society organizations working with men who have sex with men (MSM), transgender (TG) people, and injecting drug users. The USAID SUM Program provides technical assistance to civil society organizations and other stakeholders in the HIV response in two areas – organizational performance and technical capacity building.

These four manuals are aligned to the Government of Indonesia National AIDS Commission's *National Strategy and Action Plan 2010-2014*. The priority actions it outlines form the foundation of the comprehensive response to services for most-at-risk populations for HIV (MARPs) outlined in these manuals.

A Government of Indonesia priority is to strengthen partnerships between government, civil society and affected communities in the response to HIV.

Indonesia's response to HIV as described in the *National AIDS Commission's National Strategic and Action Plan 2010-2014* identifies four priority actions:

1. Prevention programs for populations most at risk
2. Strengthening of care, support and treatment services for people living with HIV
3. Building an enabling environment
4. Minimizing the negative impacts on health seeking behaviors.

Furthermore, in GFATM Rounds 8 and 9, the Indonesian Government outlined a set of key objectives, programming principles and priorities. Both rounds prioritize strengthening partnerships between government, civil society and affected communities in the response to HIV in order to:

- Interrupt the transmission of HIV among MARPS

- Provide treatment and care for PLHIV
- Achieve universal access to prevention of HIV, treatment, care
- Support health system strengthening
- Strengthen the engagement of civil society in the HIV response

Users of the Manual

The manual's primary target audience is the small, community-based CSO – i.e., an existing or newly formed CSO with one or two full- or part-time employees and a network of volunteers. Larger, long-standing CSOs will also benefit from the manual.

The intent of the manual is to enable CSO leaders, staff and volunteers alike to have a shared understanding of what they can do collectively to exercise good leadership and management and apply core technical competencies and strategies that positively contribute to a district-wide unified and coordinated HIV response.

Manual *Version One*

This manual is *Version One*. In this *Version One* a key challenge was *how much to include.* For example, Section 1 Organizational Performance could have included several additional topics, such as governance, knowledge management, policy development, resource mobilization, and so on. After much discussion, the decision was made to focus in *Version One* on the essential, core "best practices" pillars of organizational performance.

Version Two will be produced in early 2012. It will be a refined and strengthened version, benefiting from the following:

- The results of the SUM Program expanded readiness assessments (ERAs) in several communities across the country. The ERAs are used to gather what is known about current access, coverage, and reach levels for the most-at-risk populations being targeted. They focus on: organizational readiness; assessing existing community structures and norms; assessing existing community-focused services (experience, reputation, trust of most-at-risk communities, goodwill, personnel); and the potential for leveraging financial resources. A key emphasis of the ERA results is to identify strategies for how government and non-government organizations can work collaboratively to develop trusted long-term relationships with the most-at-risk populations they are trying to reach.

- The results of CSO-specific organizational performance/technical capacity (OP/TC) assessments conducted with a number of CSOs in SUM Program targeted communities. These assessments review the organizational profile of the CSO and its organizational and program management, and also assess its technical capacity. They are conducted with CSO staff in a participatory process, in which facilitators guided the process of discussion using the assessment tools. The assessment teams also verified responses by gathering information from the CSOs, such as legal documents, materials related to management systems and standard operating procedures,

financial, human resources, and assets management. The outputs from each assessment are an organizational profile, OP/TC summary of results, and a CSO organizational capacity development plan.

Version Two will also benefit from feedback from manual users – how to strengthen the content and also how to improve the manual's format and organization so it is more user-friendly.

Supplemental *How to* Materials

Another challenge faced in the development of this manual is *how to sort* the delineation of best practices and the "how to" in establishing or implementing a best practice – and keep the manual to a manageable length.

The SUM Program has a number of "how to" organizational performance and technical capacity manuals. Many of these materials were developed by its predecessor project – the USAID Aksi Stop AIDS (ASA) Project. Others have been developed in the period since the SUM Program's launch in June 2010. Throughout the manual these supplemental *how to* materials are referenced as key resources.

Over the coming years, the SUM Program will expand its list of "how to" manuals, technical briefs, and training materials based on needs identified by CSOs and other stakeholders.

A Comprehensive HIV Response to MARPs: *Role of the CSO*

Identifying MARPs and those Affected by HIV

The HIV epidemic in Indonesia is classed as a concentrated epidemic, which still largely affects people who have at least one high-risk behavior:

- Injecting drug users (IDUs)
- Female sex workers (FSW) and their clients
- Transgendered persons (*waria*)
- Men who have sex with men (MSM)

Many MARP members engage in more than one high-risk behavior. Sexual partners of people who have high risk behaviors are also at risk, and so HIV can spread beyond MARPs. This has already happened in Tanah Papua, where an estimated 2.4% of the general adult population is infected with HIV (Ministry of Health and Statistics Indonesia 2007).

Accordingly, the response to HIV needs to be targeted towards those most at risk of acquiring or transmitting HIV and on those most affected by HIV. In Indonesia this includes:

- Men, women and *waria* who sell sex
- Men who buy sex from men or women or *waria*
- Men who have sex with men
- People who share needles when they inject drugs
- Other drug users, especially ATS users
- Men and women with multiple sexual partners
- Wives and longer-term sexual partners of men who buy sex or inject drugs

Waria

HIV prevalence among *waria* in Indonesia has been steadily rising since surveying of *waria* was first initiated in 1995. The 2007 IBSS of five cities in Indonesia also included surveying waria in Jakarta and indicated that HIV and STI prevalence rates among *waria* remain extremely high. 34% of the 2007 IBBS sample tested positive for HIV, 42.2% tested positive for rectal gonorrhea or chlamydia while 25.2% tested positive for syphilis. 82.4% of the *waria* surveyed sold sex and a *waria* is more likely to acquire HIV the longer she engages in sex work: the survey indicated an HIV prevalence of 15.8% among *waria* who sold sex for less than a year while it was 39.1% among waria who sold sex for more than one year.
In Jakarta, 73.2% of the *waria* sample had visited an STI clinic in the three months prior to IBBS surveying while 60.4% had undergone HIV testing in the year prior to the survey. 64.4% indicated that they know condoms protect against STIs and HIV but only 15% of the sample said they had always used condoms at receptive anal intercourse in the past month. Only 44.4% of the Jakarta sample indicated they carry condoms and lubricant with them. The gap

between what a *waria* knows about safer sex and the actual sex she engages in (safe or unsafe for HIV) needs further investigation. Further research is needed to understand how the dynamics of poverty and the social and legal environments affect safer sex choices among *waria*. The findings suggest that, despite CSO links to clinical and other service providers and the strong networks among *waria*, HIV is not being interrupted among them and that the negative impacts of living with HIV for *waria* are not being mitigated. This speaks to the need for dramatically improved organizational technical strength and skills in order to raise the standard of HIV education and HIV support, across the entire provincial response to HIV among *waria*.

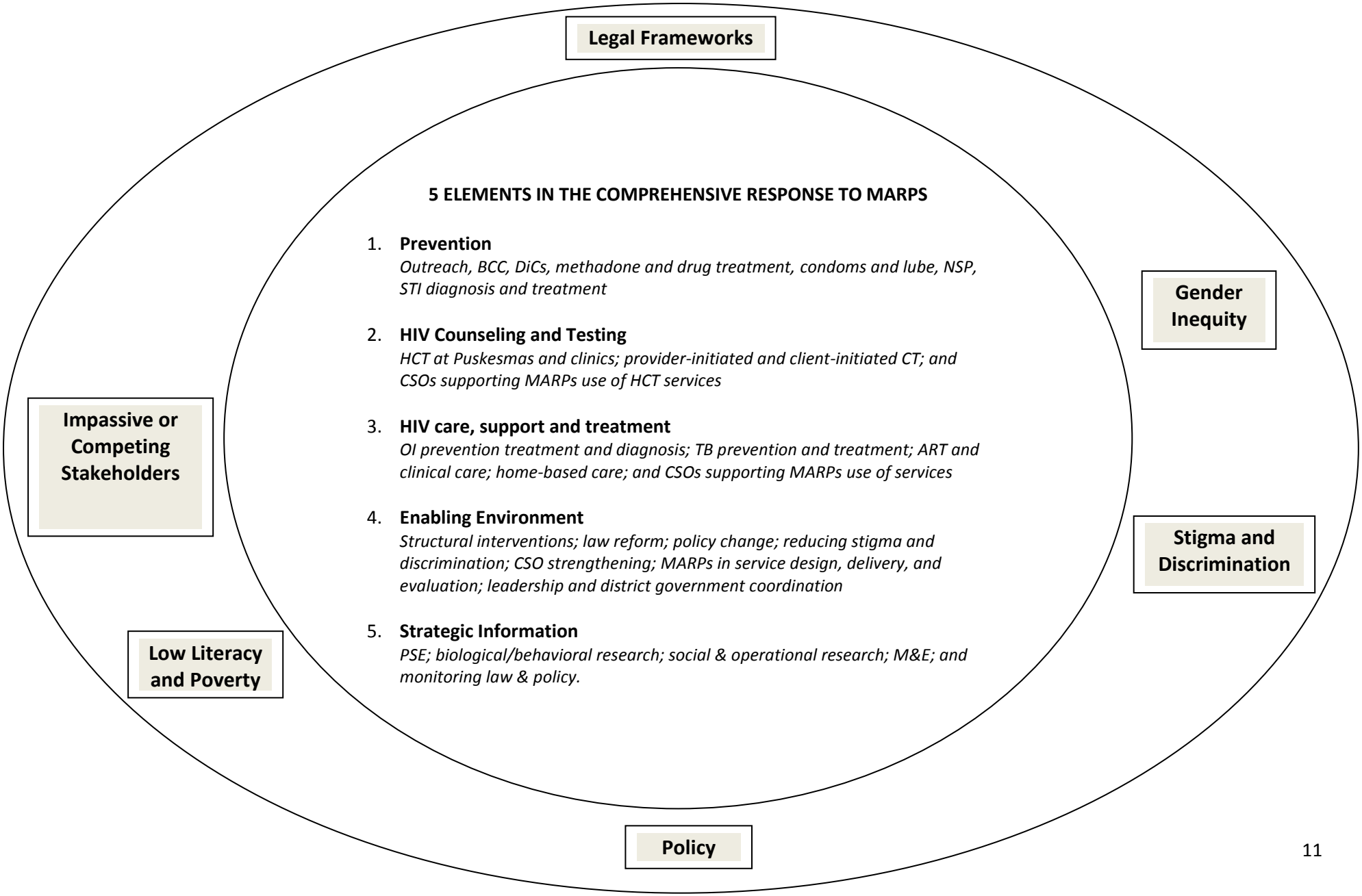
Defining a Comprehensive Approach to HIV Services for Most-At-Risk Populations

In this manual, a comprehensive approach to HIV services for most-at-risk populations includes the following key elements:

1. Prevention
2. Knowledge of HIV status
3. Care, support and treatment
4. Creating an enabling environment
5. Strategic information

This comprehensive approach is illustrated in Diagram 1 below. It describes in the inner circle the five elements of the comprehensive response to MARPs and, in the outer circle, identifies constraints in the environment that can impact negatively on the HIV response. This section provides definitions of the five elements and the environmental constraints and illustrates the role of the CSO.

Diagram 1: Elements of the Comprehensive Response and Constraints



THE INNER CIRCLE – 5 ELEMENTS IN THE COMPREHENSIVE RESPONSE TO MARPS

1. Prevention

Prevention services aim to initiate and sustain behaviors which prevent HIV transmission among most-at-risk populations. Interventions can include:

1) Outreach and peer-based education, including condom and lubricant, needle and syringe distribution and internet-based information and support
2) Information Education Communication (IEC) and Behavior Change Communication (BCC)
3) Drop-in center services
4) Increased access to methadone services and drug treatment for drug users
5) Access to Post Exposure Prophylaxis (PEP) for HIV
6) STI prevention, screening and treatment, including presumptive STI treatment for sex workers.
7) Targeted mass media

Role of the CSO

Prevention is core business for CSOs. CSOs take a leading role in working with MARPS **to connect them long-term with the HIV prevention messages, programs and services** they need.

The contribution CSOs can make as leaders in the HIV response at provincial- and district-levels is threefold:

1) Outreach to MARPs to ensure they are connected long-term with the HIV prevention messages, programs and services they need
2) Direct provision of MARPs prevention messages, programs and services
3) Facilitate MARPs participation in developing local government prevention messages, programs and services.

CSO service provision

One CSO started its MSM and TG program in 2008, when it stepped in to fill the void after another organization had to close. Until that time, the CSO had been providing general health services, but it was lucky enough to inherit trained outreach workers from the organization that had closed. These workers were able to sensitize the CSO staff and provide expertise on working with MSM and TG persons. This complemented the CSO's established strength in providing medical services.

The program began by mapping "hotspots" to identify where the needs were, and responded by providing the following services:

- Outreach, including edutainment sessions, in MSM hotspots – massage parlors, saunas, and public places such as bus stations and shopping malls – to promote VCT and STI services, and case management services for MSM and TG persons living with HIV;
- Counseling services, including pre- and post-test HIV counseling;
- A mobile clinic;
- A hotline information service that proved popular with non-gay identified MSM who may also have girlfriends or be married with children;
- An HIV education series on a local radio station for popular *dangdut* music. This was at the request of the radio station, which was committed to providing HIV information to MSM and TG persons.

A major goal for the CSO is to be recognized for their leadership role in HIV prevention (and therefore limiting the transmission of HIV to the general population) *as demonstrated by discretionary line items in provincial and district HIV response budgets.*

2. HIV Counseling and Testing

HIV Counseling and Testing (HCT) – knowledge of HIV status among MARPs – is a government priority. Knowing one's HIV status is a crucial step in interrupting HIV transmission and mitigating the negative impacts of living with HIV. MARPs can get access to HCT through some *Puskesmas*, mobile clinics, and CSOs. These services are limited and not available everywhere. Some HIV-related CSOs are doing counseling, but, in most cases, *Puskesmas* and CSOs will need to refer for testing.

Role of the CSO

CSOs play a unique pre-counseling role by encouraging MARPs to **access VCT and to use the results of VCT to improve their health** – either by reinforcing the need for people without HIV to avoid acquiring HIV in the future or by working with people diagnosed with HIV to assist them in gaining access to HIV care, support and treatment and to avoid transmitting HIV. The key emphasis is on:

- Motivating persons to know their HIV status
- When status is HIV positive, quickly initiating behavior change and risk reduction strategies to avoid further transmission to uninfected persons
- Immediate access to care, support and treatment services to improve quality of life.

CSOs also play a role in mentoring and supporting clinical staff and clinical teams in *Puskesmas* and hospital settings to learn about the unique clinical presentations of MARPs and to modify service design so it can be tailored to the needs of MARPs. As such, CSOs can promote health-seeking behaviors among MARPs patients simply by helping to create a friendly and supportive environment.

The role of CSOs in mentoring and supporting clinical staff and clinical teams in *Puskesmas* and hospital settings, in many places, is a challenge. The power relationship is imbalanced between CSOs and health services providers in the Indonesian setting. For example, it may be very challenging for the CSO to provide mentoring and support to clinical staff to ensure that they complete documentation of referral for most-at-risk populations.

3. Care, support and treatment

The provision of clinical and community-based services that have expertise in and sensitivity toward HIV negative and HIV positive MARPs is essential. Potential interventions include:

1) Surrogate marker testing (CD4)
2) Opportunistic infection prevention, treatment and diagnosis
3) Tuberculosis prevention and treatment
4) Antiretroviral treatment and clinical care
5) Home-based care
6) Community peer support and counseling services for MARPs living with HIV
7) Case coordination of services to meet the broader health needs of MARPs with HIV

Role of the CSO

CSOs play a key role in establishing networks to link clients to community-based health facilities and facilitating referrals to **enable MARPs to access care, support and treatment services** when they are living with HIV infection. And they can also play an important case management role that complements the clinical service delivery and promotes lifelong health-seeking by MARPs.

In their role as case managers, CSOs often play a mentoring and supporting role for clinical staff and clinical teams in *Puskesmas* and hospital settings, enabling them to help modify services so they are more appropriately tailored to the needs of MARPs. Specifically, CSOs:

- Establish referral network to ensure access to health services is provided for MARPS through the coordination of health service providers
- Ensure confidentiality
- Ensure health providers complete documentation of referrals for MARPS

COMPREHENSIVE AND INTEGRATED INTERVENTION

Diagram 2, illustrates a Comprehensive and Integrated Intervention (see page 17), how prevention, HIV counseling and testing (HCT), and care, support and treatment (CST) services are woven together as an umbrella of interventions for ensuring a continuum of care for MARPs and PLHIV.

Prevention services aim to initiate and sustain behaviors that prevent HIV transmission among most-at-risk populations. Prevention includes behavioral interventions, effective STI treatment and preventing mother-to-child transmission. Knowing your risk for HIV, promoting condom use and use of sterile injecting equipment as methods to prevent HIV and regular health checks and Periodic Presumptive Treatment (PPT) are methods to maintain health.

HCT is the gateway linking prevention with care, support and treatment. Knowing one's HIV status is a crucial step in interrupting HIV transmission and/or mitigating the negative impacts of living with HIV. It can best be facilitated by ensuring that MARPs have access to effective and sensitive clinical services that, by providing a supportive environment, can promote health-seeking behaviors among MARPs. This step involves Voluntary Counseling and Testing (VCT) through Puskesmas, mobile clinics, CSOs as well as Provider-Initiated Testing and Counseling (PITC).

Care, Support and Treatment (CST) includes the spectrum of services starting with prevention case management and moving toward clinical treatments and support. The provision of clinical and community-based services that have expertise in and sensitivity toward HIV negative and HIV positive MARPs is essential. The range of interventions includes case management, home and community based care (HCBC), support groups, counseling, TB prevention and treatment, Antiretroviral Treatment (ART) and clinical care, Opportunistic Infection (OI) prevention, diagnosis and treatment, and Cotrimoxazole Preventive Treatment (CPT).

- Track referrals to ensure appropriate follow up is provided and to identify and fill any gaps in service delivery
- Create a positive feedback system to health providers to improve the quality and sensitivity of services to MARPs' needs.

4. Creating and Sustaining an Enabling Environment

A comprehensive prevention approach entails understanding the structural barriers to HIV health seeking confronting MARPs. These are likely to be at the level of policy, service design, legislation, and law enforcement agency practices. Potential interventions to be explored include:

1) Harmonizing HIV policies and practices with legislation and law enforcement
2) Reducing harassment, violence, stigma and discrimination experienced by MARPs
3) Ensuring continuity and consistency of programs and services through advocacy and leadership building
4) Debt reduction and poverty alleviation
5) CSO strengthening through organizational capacity development
6) Promoting the involvement of MARPs in service design, delivery, evaluation and leadership.

Role of the CSO

The CSO can work closely with district and provincial government officials, who have an important role to play in promoting cooperation and collaboration between all parts of government and across sectors engaging in the HIV response. The CSO can be a catalyst in identifying and removing barriers to health-seeking behaviors. Partners include police, local authorities, community formal and informal organizations, and bar and brothel owners. CSOs can coordinate closely with district-level KPA, an important leader in supporting scale-up of services which reach MARPs at the local level.

Specifically, the CSO as leaders in the HIV response can:

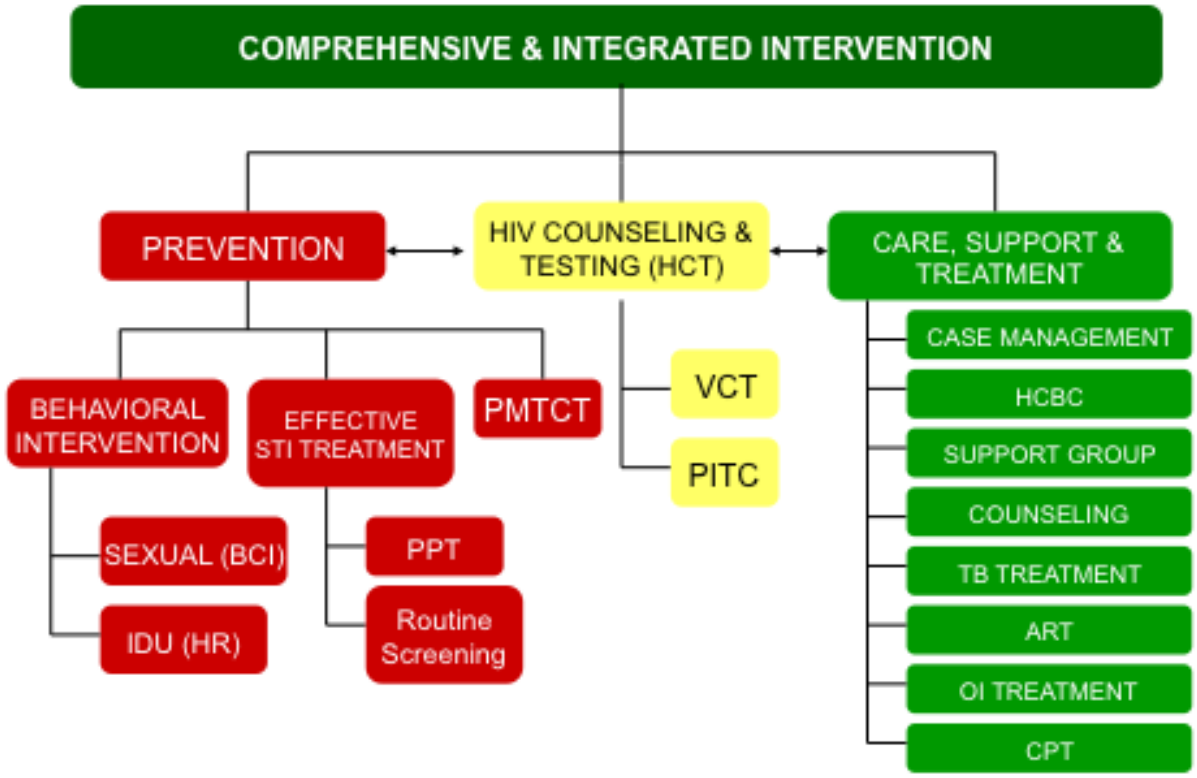
- Promote regular coordination meetings to identify barriers that address:
  - Harmonizing HIV policies and practices with legislation and law enforcement
  - Mobilizing the community for reducing harassment, violence, stigma and discrimination experienced by MARPs
  - Ensuring continuity and consistency of programs and services through advocacy and leadership building
  - Debt reduction and poverty alleviation
- Provide organizational capacity development to strengthen community-based support services

- Promote the involvement of MARPs in service design, delivery, evaluation and leadership.
- Advocate for discretionary line items in provincial and district HIV response budgets to support and expand (scale up) CSO and other stakeholder HIV programs and services.

They can also play an important advocacy role to assure new laws (e.g., the new drug law) are understood by police, judges and lawyers and to challenge stigma and discrimination where they see it operating. They can work with politicians to change local ordinance, e.g., to enforce brothel owners in providing monthly screening of STI at *Puskesmas* and imposing condom use in brothels. They can work with the Ministry of Social Affairs to conduct vocational training for FSW. They assure (e.g., through the CSO forum) that MARPs are represented in municipal/ district planning sessions.

Diagram 2: A Comprehensive and Integrated Intervention

As illustrated here, the comprehensive and integrated intervention closely links prevention interventions with a menu of health and support services for ensuring a continuum of care and support for MARPs and PLHIV.



5. Strategic Information

"Knowing your epidemic" is crucial. Accurate and timely information about the sub-populations, behaviors and HIV prevalence of MARPs provide essential information that can help to ensure effective and relevant services and programs including:

1) Population size estimation (PSE)
2) Biological and behavioral surveillance
3) Social and operational research
4) Program and service monitoring and evaluation (M&E)
5) Policy and legislative review

Role of the CSO

In many ways, the CSO is at the frontline of MARPs activities. In this capacity, they can contribute to the mapping of the MARPs they work with – population size, location, etc. They can enlighten local government on mapping conclusions so that services and programs are accurately targeted. They can be monitoring their own programs and services and report to the local government, which enables local government to report to the national-level on government targets – which MARPs groups are being reached, and the extent they are accessing HCT and services.

THE OUTER CIRCLE – MITIGATING THE NEGATIVE IMPACTS OF HIV ON MARPS

MARPs are often described as 'hard to reach' which is sometimes, but not always the case. Certainly there are a set of obstacles and barriers that prevent the engagement of MARPs in long-term health-seeking relationships with services and programs. A key goal for a Comprehensive Approach to HIV Services for MARPs is removing these social, political and legal barriers to health seeking.

Laws and Policy

Structural interventions, particularly the legal frameworks and policy environment in relation to MARPs, are important to the delivery of this comprehensive response to HIV services for MARPs.

Many MARPs are involved in illegal activities such as selling or procuring sex, sex between men, and using illegal drugs. Drug use is illegal in many countries, including Indonesia, and this means the populations involved in these activities are often in conflict with police, local government, and local communities.

Role of the CSO

See #4 above, *Creating and Sustaining an Enabling Environment.*

Stigma and Discrimination

Advocacy and interventions to minimize stigma and discrimination are important to the Comprehensive Response to HIV service for MARPs: People from these populations – particularly those who are easily identifiable as sex workers, *waria*, drug users or men who have sex with men – may experience discrimination in health care settings and have difficult relationships with government and other services. They have either received poor treatment when they presented for health services or they have heard from others that they will receive poor treatment, and so are reluctant to present for services. Discrimination amongst health workers is high in many services, resulting in poor utilization of these services by MARPs.

Role of the CSO

The CSO can work with the *Puskesmas* to increase MARPs-specific clinic time and increase the understanding and sensitivity of clinic staff about MARPs needs, concerns and issues. They can assure that MARPs are represented in local government planning processes. They can help MARPs groups in the community form their own associations (e.g., of FSW) to advocate for reduced stigma and discrimination.

Gender Inequity

Gender inequity remains a barrier to alleviating HIV and therefore to the Comprehensive Response. Female IDU and sex workers are more at risk for HIV than other women. Female IDU are more at risk than their male IDU counterparts. Female partners of sex work clients and of MSM (where MSM have female partners) are more at risk of HIV infection than other women. Yet many MARPs programs and services have no or limited services targeted to women. In many settings transgender people are at higher risk of HIV than MSM, but programs and services focus more on MSM as they are often thought to be easier to identify and work with. (Many *waria* wish to be seen as a third gender.)

Role of the CSO

The CSO can work with the *Puskesmas* to assure women-targeted and friendly services, and to train and mentor *Puskesmas* staff on preferences and needs of women who are more at risk, including *waria*. They can promote specific programs for female partners of IDUs.

Low Literacy Levels and Poverty

Low literacy levels and poverty are important issues for alleviating HIV and to the Comprehensive Response. Access to the means of prevention and the power to make safer decisions can be reduced by low literacy, lack of education and poverty in MARPs. Many IEC

and BCC materials that might inform people about the risks of HIV infection are in writing, or in language that is not appropriate or tailored to the information/education needs of people from MARPs. With any intervention, materials should be tailored to the target population. A comprehensive prevention approach will complement knowledge with access to the means of prevention (condoms and lubricant, needles and syringes) and power to make safer decisions.

Role of the CSO

The CSO can play a role in assuring access to appropriately tailored and user-friendly written materials. They can also facilitate education sessions about HIV prevention so that needed information is provided verbally and not only in writing.

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SECTION 1: ORGANIZATIONAL PERFORMANCE

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Leadership

With the support of her family, a grant from an Embassy and a small group of *waria* friends, one *waria* established a CSO.

With the added assistance of the city government and USAID, the CSO has grown in to an organization of thirty staff and fifty volunteers, who deliver HIV outreach, distribute condoms, lubricant and information about HIV and health services to Waria across the city.

They accompany waria to voluntary HIV testing and counseling, STI diagnosis and treatment services and they provide shelter for waria living with HIV. They support *waria* experiencing problems with the police and the judiciary.

The CSO manager proudly proclaims that the CSO now serves almost 3,000 Waria across greater Jakarta.

Introduction to this Section

This section of the manual – Organizational Performance – provides guidelines and best practices in CSO leadership and management. One management function, *financial management*, and two leadership functions, *mobilizing the HIV response* and *advocacy*, are presented as stand-alone sub-sections to facilitate their use in start-up activities and external presentations and training sessions.

As a preface to this section, information is provided here on types of organizations and structures of non-profit organizations within the definition of Indonesian law.

Types of Organizations

Groups form and contribute to the local HIV response in different ways. When people formally gather to accomplish certain goals they are *organizing together* and this grouping can be called an *organization*. Individuals often come together and form an organization because they have not been able to meet their goals alone.

Organizations are social and collective by nature. They are deliberately formed and are goal-oriented. The most effective organizations are purposeful in building networks and aligning other groups and institutions in the external environment behind their vision and goals.

The freedom to associate is guaranteed under the Indonesian Constitution 1945 (as amended), specifically in Article 28E Clause 3. The Indonesian Civil Code (KUHPer) Article 1652-1655 provides clear guidance on the nature and function of organizations and the role of governing structures in the management of these organizations.

There are many different types of organizations in Indonesia and these can be grouped in several ways:

- **For-profit** organizations – aspire to generate income for the financial benefit of individuals in the organization.

- **Not-for-profit** organizations – profits are retained by the organization and used to fund organizational activities and programs.

- **Formal** organization – has a legal entity status gained through compliance with government-required procedures.

- **Informal** organizations – no legal status.

- **Membership-based** organizations – size is determined by the number of members, and decision-making rests with the deliberations of all members or their representatives.

Non-profit organizations with memberships might be called *Paguyuban* (friendly association or club).

- **Not membership-based** organizations – decision-making processes not dependent on a membership of any sort. Not-for-profit organizations which are not membership-based are called *Yayasan* (foundation).

Structures of Not-for-Profit Organizations

As noted above, not-for-profit organizations in Indonesia tend to be *Yayasan* or *Paguyuban*.

Yayasan

By law, these organizations have no members. The ultimate, highest decision making power of a *Yayasan* rests with its Board of Patrons, but other elements of the governance structure include the Board of Directors, Supervisory Board, and Executing Team (paid staff members). Many educational institutions (schools and universities) are owned by or are in the form of *Yayasan*. A *Yayasan* is directed towards achieving certain objectives within the social, religious and humanitarian realms.

A *Yayasan* may conduct revenue generating activities to attract funds in order to achieve its goals and objectives. To do so, they can form a business company or join an existing enterprising company, provided that the business is compatible with the organization's objectives and satisfies certain other requirements. Salaries may not be paid to members of the organization's Board of Patrons, Board of Directors or Supervisory Board.

If a *Yayasan* is founded by MARPs, the founders will generally become members of the Board of Patrons. MARP influence over the organization will be further strengthened by inclusion of MARPs representatives as members of the Board of Directors.

See the text box on the adjacent page for additional resources that provide detailed information on the laws relevant to a *Yayasan* and the steps involved in setting one up.

Paguyuban

Paguyuban (or *Perkumpulan*) are membership-based entities. Examples include groups of people of the same profession, those living in the same area or having the same hometown, people using the same make and type of motorcycle, or people suffering from the same health problems. The *Paguyuban* is a system of social relationships not motivated by economic objectives. Not all Paguyubans have legal status, but many do. This legal status is achieved via compliance with an established process which can take considerable time.

Paguyuban structures often resemble those of Yayasans. The main difference is that in a *Paguyuban* the members of all the organization's structures will be elected *by the members* from *among the membership* itself. The ultimate decision-making power of the *Paguyuban* rests with the members. A *Paguyuban* may also hire professional staff to run the day to day operations of the organization when it is deemed necessary.

Additional Resources

The USAID SUM Program *CSO Start-Up Module* includes additional information on governance, and *Paguyuban* structures and the laws relevant to these organizations. (Note: The guide is only available at this time in Bahasa Indonesia.)

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1. Leadership and Management

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1.1 Defining Leadership and Management

A complementary set of skills and behaviors are tied to "management" and "leadership." Both sets of skills and behaviors are important for an organization's success.

Leadership skills and behaviors are needed when bringing about major change – for example, scale out of a unified, coordinated HIV response; an end to stigma and discrimination; budget allocations by local government to CSOs that provide MARPs services and programs; and a break in the transmission of HIV.

Management skills and behaviors help to bring quality and access to specific programs and services.

Leadership and management skills are required at all levels of the organization, not just by the CSO executive director. An effective leader operates in <u>both</u> parts of the leadership and management framework[1]. He or she is able to:

Leadership *Doing the Right Things*	**Management** *Doing Things Right*
❑ **Collaborative Leadership** *Collective vision* *Collective strategies* *CSO Strategic Plan*	❑ **Stewardship over:** *Goals* *Objectives* *Resources* *People*
❑ **Building Alliances and Coalitions** *Mobilizing Influence leaders, volunteers, and other key stakeholders in communities* *Advocacy with provincial and district officials*	❑ **Performance Management** *Planning* *Implementation* *Monitoring* *Feedback* ❑ **Financial Management**
Brings Change	**Brings Quality and Access to Services and Programs**

<u>Leadership Functions and Skills</u>

- Engage others in developing a vision of positive change
- Determine strategic priorities – *Doing the Right Things*
- Build coalitions and partnerships across the community in support of programs and services.
- Motivate and inspire others to move forward, get things done – a bias for action.

[1] Adapted from *Leadership and Management,* by John Kotter

Management Functions and Skills

- Focus on quality and access to services and programs – *Doing Things Right.*
- Enable others to take action by appropriately delegating authorities.
- Foster teamwork at every level and seek to bring out the best in individuals and teams.
- Communicate clear performance expectations of others. Staff knows what they are being held accountable for and are trusted to get the job done.
- Identify the financial and human resources needed to support quality programs and services, and use available financial and other data to analyze and manage costs and the efficiency of operations.

1.2 CSO Leadership in the HIV Response – *A Vision of Change*

There are many examples of CSOs leading change in the district-level response to HIV. CSO leaders are working with other leaders across the community to build a collective vision and common strategies directed at strengthening and scaling out the five elements of a comprehensive approach to HIV services for MARPs.

Working in collective leadership with other government and non-government entities enables a more powerful, unified and coordinated response to HIV. It also empowers the CSO in its own strategic thinking and planning process – that its contribution, small or large, is a critical element in the overall response.

CSO Networks Bring Collective Leadership to the HIV Response

CSO networks are an effective way to bring collective leadership to the HIV response.

Jakarta

The Jakarta CSO Forum for HIV consists of 30 CSOs working in the HIV response. They are equal partners on the Jakarta Provincial AIDS Commission and are fully engaged in the provincial strategic planning process. They also participate with the USAID SUM Program in the selection of grantees.

Malang

The Malang CSO Forum for HIV was established because CSO leaders agreed their advocacy will be more effective if they form a coalition. A main goal is to raise issues about clinical and other government services with local government officials.

Their efforts have already resulted in local legislation – passed in 2008 as Law No. 14/2008 – mandating district government's participation in the HIV response, which enables HIV programs and services to be funded by local government.

There are also many examples of CSO leaders advocating for change in local ordinances, policies and health delivery services to bring about a more conducive environment for HIV interventions. They are mobilizing community leaders and other key stakeholders to participate in and eventually own and manage HIV program and service interventions.

Included here are specific ways that CSO leaders can contribute to the district-level response by building alliances and partnerships[2]:

- **District AIDS Commission (KPAD)**

CSO leader are informing KPAD about the needs of most-at-risk populations for service; advocating for improved and futures services; participating in District AIDS Commission (KPAD) leadership meetings; representing MARPs in district planning processes; sharing insights and information about constraints and issues in the environment faced by the CSO's MARPs constituency; and providing KPA with feedback on issues in the community and targets being met.

- **District Office of Health (DOH)**

CSOs play an important role in referring clients to the *Puskesmas*. Service utilization of HCT and treatment relies heavily on CSO outreach activities with most-at-risk populations. Moreover, *within* the *Puskesmas* and District Hospitals, the CSO is engaged in outreach to staff, and providing mentoring

The Goal of One CSO
A Community Service Organization Led by Waria

One *waria*-run CSO has a unique model for community practice based strongly in bonds between *waria* and in a strong sense of their own independence and shared sense of 'family' and fidelity to each other. Often *waria* come from other cities and they have no families locally so they support each other.

The CSO is providing these services:

- outreach education
- BCC and condom distribution and peer norming for condom-use and adhering to ART
- peer support
- referral networks
- links and partnerships to mainstream organizations
- home-based care
- income generation

The CSO has been running for more than 30 years, with or without funding, and they feel that their strength comes from their sense of 'family' and fidelity to each other. They feel their CSO is sustainable because of this common bond and their volunteer approach.

[2] Interviews and focus groups with approximately 100 people were conducted during August-October 2010 by the USAID SUM Program. They included CSO, provincial and local government, and MARPs leaders in Jakarta, Surabaya and Malang.

and training to lessen stigma and discrimination and promote friendly services. For example, in the past, the CSO accompanied clients to *Puskesmas*; now the CSO works with DOH to create friendly services so clients are willing to go alone to the *Puskesmas*.

- **Senior Provincial and District Government Leaders**

The CSO's main target for relationship-building within local government is the DOH, who becomes the entry point for the CSO to work across other parts of local government, e.g., education, socials affairs, labor, youth, and tourism. CSO leadership across other parts of government can help assure participation of MARPs subgroups in program design and decision making. Building these relationships positions the CSO for future funding opportunities through the local government budgeting process.

- **Members of Parliament**

CSOs are identifying advocates for MARPs among members of Parliament, participating in Parliament committees, and providing continuing information about environmental constraints to HIV interventions. (See adjacent text box.)

- **National NGOs with Local Networks**

CSO leaders are exchanging strategic information with larger, nation-wide NGOs about the district-level HIV situation and the MARPs they represent. They include the Indonesian

CSO's Leadership Role in the District-Wide HIV Response

…At first their strategy was to be critical and angry.

A CSO in Malang plays a leadership role in the district-level HIV response by facilitating communication and cooperation between female sex workers and local government. Sex work is illegal in Malang District and the CSO has an ongoing advocacy campaign to change the law. They originally started the advocacy campaign to raise awareness of the plight of female sex workers.

At first their strategy was to be critical and angry and approach government only when there were problems with services. This did not achieve any lasting relationships with government. So, they changed their strategy.

They began attending parliamentary meetings and district-level health and welfare forums to find champions of female sex workers within the legislature. They searched for politicians who were championing issues for women and girls. They brought the politicians and government officials to brothels. They talk to them about the successes they were achieving at the grassroots level getting 100% condom use in brothels. They presented information and evidence to politicians about the problems of HIV. This strategy was very successful partly because they were inviting government to participate in and celebrate success.

They targeted the Bupati (Head of the District) for advocacy and relationship building. Initially they approached the Deputy Bupati who was the chairman of the District AIDS Commission and through him were able to set up meetings with the Bupati directly. They used opportunities including cross-district forums to speak about the issues of FSW and talk with the Bupati directly during breaks in the meetings. They eventually convinced both the Bupati and the Deputy to raise the issue of HIV in the parliament and push government to provide greater support for HIV prevention and care services.

This leadership by the CSO helped raise awareness of sex work and HIV and led to parliamentary discussion forums on HIV and sex work that involved community leaders, religious leaders and other local authorities.

faith-based organizations, *Nahdlatul Ulama* (NU) and *Muhammadiyah*, the Indonesian Planned Parenthood Association, and the Red Cross. National NGOs and their local representatives gain an extension of their own networks through the smaller localized and specialized CSO; and potentially gain a future partner in their small grant and in-kind programs.

- **Influence Leaders in the Community**

CSO leaders are reaching out and building relationships with influence leaders across the community and helping these leaders understand that services for most-at-risk populations protect the entire community. They include religious leaders, community leaders, former political leaders, and local musicians and artists. They are tapping these influence leaders for as program volunteers, as contributors to CSO strategic planning and program implementation, and for special awareness raising events.

Networks

The *Jaringan Peduli AIDS Malang Raya* (Network of AIDS NGOs in Malang District). brings together CSOs working with MARP. They build relationships with organizations such as PLHIV support groups, student groups and CSOs not working on HIV. The forum aims to share information and find solutions to problems. They use the group as an advocacy tool for raising problems experienced in hospitals, clinics or other government services in the district. This forum was an important resource for mobilizing a political campaign for talking to district government and the parliament.

CSO members of the *Indonesian National MSM Network* have used this network to raise awareness at national level of problems and issues at the local level. For example, when condoms and lubricant stocks ran low or ran out, CSO members informed the national network, who in turn raised the problem at national level for resolution. In another example, Malang city was without a *Puskesmas* with responsibility to provide STI services. One CSO raised the issue with the national network who took it to the National AIDS Commission (KPA). The KPA then raised the issue formally with the local municipal government and a *Puskesmas* with responsibility for STI diagnosis and treatment was established.

A *Waria*-led CSO's role in the Provincial-level Response to HIV

One *waria*-led CSO's role in the provincial-level response to HIV in DKI Jakarta emphasizes linking waria to public health services The CSO acts as a motivator of better health seeking behavior among waria while assisting *waria* experiencing difficulties with their families, with public order authorities and the law. Several characteristics of the CSO appear significant to their success. First, they are *waria* themselves and understand many of the issues affecting other *waria*. Second, because their service design reveals a concern for the range of issues affecting *waria* lives – not just *waria* capacity to transmit HIV to others – they appear to be trusted by *waria* networks across Jakarta.

The CSO's service model integrates HIV prevention, treatment, care and support through the delivery of HIV outreach, combined with voluntary testing and counseling for HIV and STIs and combined with community care and support services for *waria* living with HIV. Each of these core services is linked to a service partner or organization in the city forming a network of service partnerships.

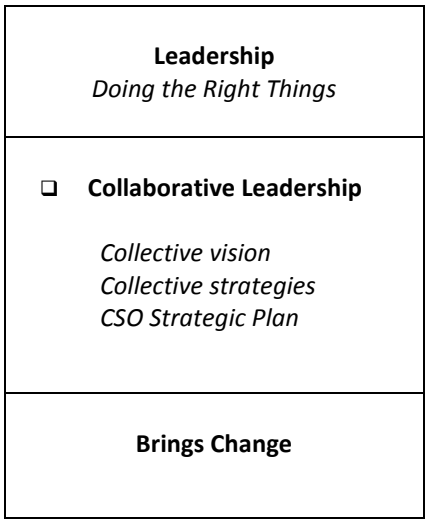
The CSO's HIV outreach services work in synergy with a group that aims to promote the positive role of *waria* in Jakarta and to advocate for their human rights. This connection allows the CSO to combine HIV outreach services with advocacy and legal representation for *waria*.

The CSO's VCT and STI support services partner with an NGO clinic where *waria* from the CSO volunteer as 'front of house' staff and as VCT Counselors for *waria* patients. This connection allows the CSO to combine supporting *waria* to know their HIV status with testing and treatment for sexually transmitted infections.

The CSO's community care and support services partner with another NGO clinic, which allows the CSO to combine community/peer-based case management with clinical care and antiretroviral treatment. The CSO also maintains links with a range of primary health clinics and ART hospitals but these links are not as strong – and this would appear to be the next strategic step needed to assist the CSO in scaling-up services in partnership with public health sites across the city.

In spite of this synergy, the CSO's role in the provincial response to HIV for *waria* in areas such as their 'reach' in to the health system, government, law enforcement and the judiciary remains severely limited by social and legal impediments that prevent their full participation and involvement within these sectors and institutions.

1.3 CSO Strategic Plan



A CSO strategic plan describes in written form the goals and objectives of the organization for the coming period, usually 3-5 years. The development and publication of a strategic plan can help build confidence – among members and partners – that the organization is professional and capable and listens to and cooperates with others. It can ensure the relevance of the organization and define the points of collaboration with partners.

1.3.1 Elements of a CSO Strategic Plan

A strategic plan should be tailored to the specific needs of the organization. An agreed-upon, consistent format becomes part of the shared language of the organization. When staff learns this language, they become empowered by the organization to think and plan strategically. The sample format below is commonly used by CSOs:

1. ***Vision of the Organization:*** A description of the organization's vision, in the open section in a strategic plan, provides a unifying framework for strategic priorities and goals. The vision description should be limited to 2-3 paragraphs to assure that it is memorable.

2. ***Core Values:*** Organizational values are a composite of principles, higher ideals and commitments that staff strives to operate by. Identify 4-6 core unifying values and put them up front and center as what matters most in the work of the organization. This unifying set of values helps guide choices of action regardless of the situation.

3. ***Strategic Priorities:*** A strategic priority is a broad statement of response to a challenge or opportunity that is fundamental to achieving the vision.

4. ***Goals:*** A goal defines one of the outcomes required to address a strategic priority**.** A set of goals may be implemented concurrently or successively. The timeframe for completing this set of goals – concurrently or successively – should be specified.

5. ***Objectives:*** An objective defines one of the interventions required to achieve a goal. Objective statements are SMART – Specific, Measurable, Action-Oriented, Realistic, and Time-bound.

6. ***Key Milestones:*** A milestone defines one of the actions or deliverables required to meet an objective.

7. ***What Success Will Look Like (Indicators of Achievement):*** The statements of success describe the results of the met objective.

8. ***Resources:*** Tied to the key milestones identified to meet a specific objective

Examples of Strategic Plan Elements

CSO Vision for *Waria*

HIV transmission is slowing throughout the district. Waria have access to quality, friendly and comprehensive health services. HIV policies and practices are harmonized with new local ordinances and law enforcement. Public awareness is high that a focused, unified and coordinated HIV response is benefiting all citizens, as demonstrated by their support for local government budget allocations for HIV programs and services. Etc.

CSO Core Values

- ***Collaborative Leadership**: Promoting collective strategies and a unified, coordinated HIV response across local government, other CSOs, MARPs champions, and health services practitioners.*
- ***Participation of MARPs:** Build trust and positive relationships with MARPs, and promote their full participation in CSO service design, delivery and evaluation.*
- ***Sustainability of HIV Programs and Service:** Commitment to local sustainability of HIV programs and services.*

Strategic Priority #1: Increase MARPs Outreach and Education Activities

Goal 1: Cadre of CSO volunteers capable of delivering HIV prevention messages and effective education sessions targeted at waria.

By December 2011

Objective 1: Twenty CSO volunteers have graduated from the 2-day *HIV Prevention and Education Session Targeted for Waria* – a course based on national guidelines for prevention and education interventions.

Key Milestones in 2011:

- Training plan completed by September 2011.
- Course design and materials finalized October 2011.
- Volunteers identified by October 2011
- In-house training-of-trainers held and course preparation completed by November 2011.
- Two courses of 10 volunteers each held by December 2011

What Success will look like:

- Participants rate the course as excellent in the course evaluation.
- Participants are able to demonstrate effective communication of prevention messages and skills in using prevention materials (condoms and lubricant).

Estimated Budget: IDR 6-8,000,000

1.3.2 Steps in Developing a Strategic Plan

Strategic planning can be pursed in different ways, but a standard approach involves seven steps, as outlined below:

Step 1: Establish a Strategic Planning Team

This step involves setting up a team to lead the strategic planning effort, usually a member from the Board or Management Committee, a senior manager, and a staff member or volunteer. This team develops an action plan indicating what needs to be done, by whom and by when.

Step 2: Announce the Strategic Planning Process

Identify the organization's key partners and stakeholders (i.e., those who can usefully contribute to the process or who have a particular stake in the organization's work), and announce the strategic planning process.

Step 3: Desktop Review of Literature and Analysis of Implication for the Organization

Review latest guidelines and literature in the strategic areas of interest, e.g. HIV prevention interventions for *waria*. This information may be located through Internet searches and contacts with government agencies and local or international NGOs. Ideally, this work should be put together in a discussion paper, but the most important thing is that this evidence is *considered* in the context of developing the plan.

Step 4: Engage a Broader Audience and Draft the Plan

Engaging staff, volunteers, Board members and key stakeholders in the process of strategic thinking and planning will contribute to the relevancy and strength of the strategic plan. The goal of this step is to clarify the current situation and MARPs needs by presenting and discussing the literature review and by soliciting participants' information about the HIV response and environmental factors impacting on health seeking behaviors. One approach for engagement may be to:

- Conduct an initial meeting with clients, staff, volunteers and Board members
- Follow this with a meeting of external stakeholders
- Follow this with another meeting in which the organization reports back meeting outcomes to clients, staff, volunteers and Board members.

Sub-teams can be assigned specific strategic priorities to draft goals, objectives, milestones, indicators of success, and the budget (see illustration above).

Step 6: Review the Draft with Key People

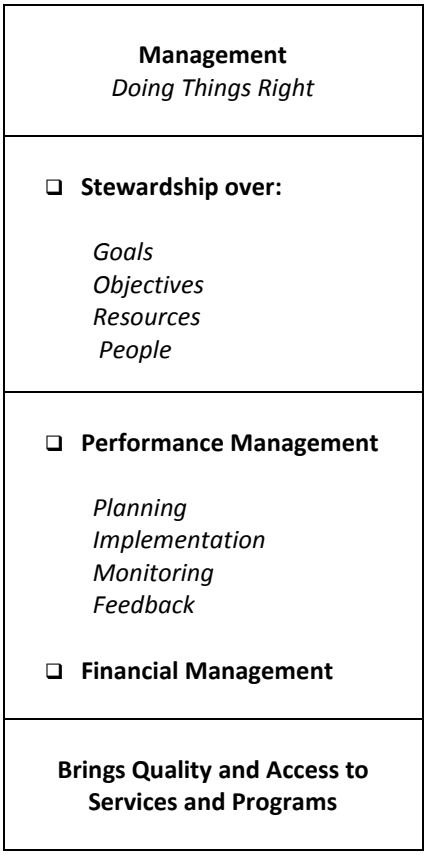
Feedback on the draft strategic plan from the Board and key partners is a critical and valuable step in the process. Are the goals and objectives realistic and achievable? Are the indicators of success clear? Is the budget estimate reasonable?

Step 7: Publish and Launch the Plan

Launches can be used as opportunities to advertise the organization and build support for its mission and programs.

1.4 Human Resources Management

On the "management" side of the leadership-management framework, stewardship over goals, objectives and human resources (HR) is a key management function. It includes the professional development of volunteers and employees so that they become more valuable to the organization and contribute effectively to achieving its goals and objectives. An organization is only as good as the quality of its human resources.



1.4.1 HR Policies and Procedures

Written human resources policies and procedures (HRPP) will:

- Help employees succeed because the rules are clear
- Clarify for everyone the rights and responsibilities of both the employer and the employee, as well all rules and regulations which may apply
- Clarify procedures that the employee should obey and follow during his/her employment

HR policies and procedures should be documented in a booklet. Small CSOs may not have a formal presentation of these policies and procedures but should somewhere have policies and procedures written down. Since a CSO is very likely to involve volunteers, the policy should also clarify the rights and responsibilities of volunteers, and the rules and regulations that may apply to them.

It should be a standard practice that every new staff member hired is given a copy of the HRPP document. Workers should be encouraged to sign employment contracts which include a statement such as: *I have duly read and fully understood the contents and meaning, and the consequences of the (name of CSO) HRPP that shall govern my employment with (name of CSO)*.

1.4.2 Volunteers and Employees – Recruitment and Professional Development

For the CSO implementing HIV response programs or services, there are two types of employees that may need to be recruited:

Steps in Recruiting Staff

- Conduct job analysis and define position(s) required
- Write a job description
- Advertise the job announcement
- Form a small recruitment committee
- Shortlist applicants
- Conduct interviews
- Request two professional references
- Make a decision on selection and offer the position to selected candidates
- Sign employment contract
- Conduct orientation and training.

CSO office staff: Regular staff such as accountant, receptionist, etc. The qualifications, responsibilities and tasks of regular office staff are very much standardized.

Program and service staff: Involves full- and part-time employees (often fixed period employment tied to a specific funder grant) and volunteers, e.g. community facilitators from a MARP group. The qualifications full- and part-time staff is not as standardized, since these are guided by the specific funding source.

See the next page for a summary of Indonesian law pertaining to HR policies and employment.

To retain your volunteers and staff, to ensure they become capable and dedicated members of your team, professional development should begin from day one. Professional development refers to skills and knowledge that helps an individual learn and grow and contribute successfully to the mission of the organization.

Professional development can include some of the following approaches:

- **Knowledge and skills training and coaching:** To enhance a person's competencies in specific skill areas by providing a process of observation, feedback, reflection and action, e.g., how to conduct an effective prevention education session.

HR Policies and Procedures
Sample Table of Contents

THE ORGANIZATION
- *Introduction*
- *History*
- *Mission*

WORK SCHEDULE
- *Workday*
- *Workweek*
- *Lunch Period*
- *Holidays*
- *Personal Days*
- *Vacation*
- *Sick Leave*
- *Bereavement Leave*
- *Time off Without Pay*

COMPENSATION
- *Paydays*
- *Compensatory Time*
- *Salary*
- *Performance Reviews*

EMPLOYEE BENEFITS
- *Social Security*
- *Benefits:*
  - *Full-Time Employees*
  - *Part-Time Employees*
  - *Volunteers*

CODE OF CONDUCT
- *Personal Conduct*
- *Visitors*
- *Security*
- *Harassment*

- **Mentoring:** To assign a senior or more experienced individual (the mentor) to act as advisor, counselor and guide to a less experienced individual.

- **Consultation:** To assist an individual or team to clarify and address immediate concerns by following a systematic problem-solving process.

- **Communities of Practice:** To improve professional practices by engaging in shared inquiry and learning with people who have a common goal, e.g., periodic opportunities as a staff or team to "take stock" of what we are doing that is working and not working in our services and programs.

- **Internal Learning Forum:** To schedule experienced individuals to conduct internal sessions for staff and volunteers on specific topics tied to the CSOs programs and services, e.g., behavior change communication.

- **Good performance management:** To manage the performance of individuals through a process of goal-setting, planning, delegation, monitoring, and feedback (see next section).

Summary of Indonesian Law on HR Policies and Employment

Chapter XI Article 108 Law Number 13/2003 on Manpower: "*Company*[3] *that employs workers/laborers at least 10 (ten) persons is obligated to prepare a company policy/regulation that becomes effective only after it is ratified by the Minister or the authorized official*."

Article 111 stipulates:

(1) The human resource policy shall at least contain:

a) The rights and responsibilities of the employer;

b) The rights and responsibilities of the workers;

c) Job requirements;

d) Company's rules and regulation; and

e) The period of validity for the regulation.

(2) Stipulations in the company's regulation shall not oppose with the existing laws.

(3) The period of validity for the regulation shall not be more than two years and must be renewed after it expires.

Many CSOs rely on rely on fixed period contracts. Most, however, do not fully follow the law regulating such employment relationships. The relevant stipulations in Law No.13/2003 are presented below:

Article 56

(1) Employment agreement is made either for a definite or indefinite period of time.

(2) Employment agreement for a definite period of time as per point (1) should be based on:

a) A fixed time period; or

b) The completion of a particular job

Article 58

(1) A fixed period employment agreement cannot include any probationary period.

(2) When a probationary period is required in a fixed period employment agreement as referred to in point (1), the probationary requirement becomes null and void for the sake of the law.

Article 59

(1) A fixed period employment agreement can *only be made for certain jobs that by its nature and type or activities are to be completed in a certain period of time, i.e.:*

a) A onetime job or temporary in nature;

b) Jobs that are estimated to finish in a not too long period of a time, 3 years at the longest;

c) Seasonal jobs; or

d) Jobs related to new product, new activities, or additional product in a trial phase.

(2) Fixed period employment agreements are not allowed for regular type of jobs.

(3) Fixed period employment agreements can be extended or renewed.

(4) Fixed period employment agreement based on a fixed period of time can be made for 2 (two) years at the most and can only be extended once for 1 (one) more year.

(5) Employer wishing to extend the fixed period employment agreement, should have informed the employee of his/her intention in writing at least 7 (seven) days before the end date of the existing agreement.

(6) Renewal of a fixed period employment agreement can only be made after a gap period of 30 days after the end of the previous agreement, and this renewal can only be done once, with the longest period of two years.

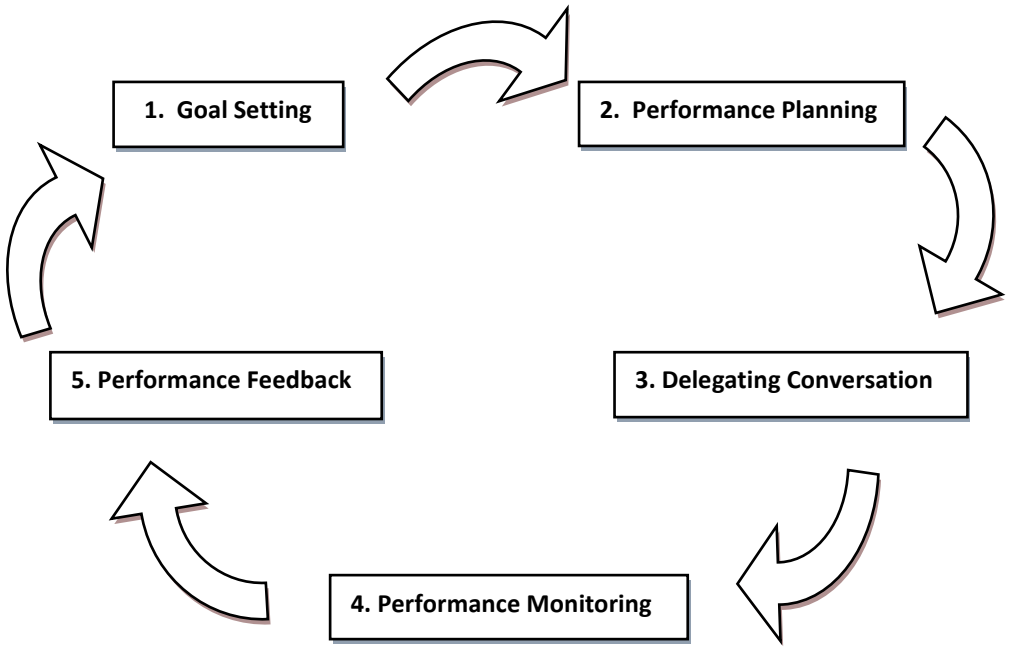
(7) Any fixed period of employment agreement that do not meet the stipulations as per points (1), (2), (3), (4), (5), and (6) will for the stake of the law become an indefinite employment agreement.

[3]Note: 'Company' includes organizations such as *Yayasan*. A comprehensive understanding of this particular law is important for CSOs anticipating growth.

1.4.3 Performance Management[4]

A key management function, as noted above, is stewardship over organizational goals, objectives, resources and people. Performance management and financial management are critical skills that enable effective stewardship.

Diagram 3: Performance Management Cycle



Good performance management not only assures program and service quality and access, but also develops employees' skills. Managing the performance of individuals requires a manager to plan, explain, clarify, test for agreement, monitor, and provide feedback. The diagram on the previous page shows a cyclical process of interdependent steps, with each step building from one to the next.

Traditionally, setting annual performance goals and indicators happens annually. Management specialists now suggest that the annual process is insufficient and recommend more frequent interaction between manager and employee or volunteer. Diagram 3, Performance Management Cycle, provides a series of steps, outlined here, that tie performance planning and delegation more closely to program quality and access goals and at the same time allows more frequent staff development opportunities – e.g., stretch assignments, positive and constructive feedback, mentoring and coaching.

1. ***Goal Setting***

[4] TRG *Performance Management Guidelines, 2009*

The organization's goals are determined as part of the strategic planning process discussed earlier. They are descriptions of intended outcomes (e.g., cadre of CSO volunteers capable of delivering HIV prevention messages and effective education sessions targeted at FSW.)

Particularly in change initiatives (i.e., the district-level HIV response), it is vital that the manager frequently and clearly explain, reiterate, and review strategic priorities and goals. These goals provide the basis for setting performance goals with an employee or volunteer and to identify what skills and capacity building individuals need to undertake their role.

2. Performance Planning

Performance planning ensures that an assignment is clearly understood and delegated. The manager's first step is to consider how the assignment is tied to a strategic goal. Explaining this link is a critical discussion point.

3. Delegating Conversation

This conversation uses the planning from the previous step. There are six suggested steps to in this meeting:

1) Review of strategic goal
2) Describe the task or assignment
3) Elaborate on the reasons for the assignment:
    - Why this person as chosen for the assignment
    - Special factors – urgency, location, etc.
4) Get input – reactions, questions, options
5) Clarify support, roles, authority, timeframes, resources, quality standards, and next steps.
6) Summarize agreements and check-in points.

The outcomes for this discussion are *understanding***,** *agreement***,** and *commitment* – providing both the manager and the individual with a clear path in successfully completing the effort. The manager's primary responsibility, from this point on, is to provide agreed upon support and to monitor quality and progress.

Performance Planning Considerations

- **What** do you want to have done for what outcome?
    - What are the major tasks?
    - What materials, contacts, and fiscal resources are required?
    - What decisions is the individual empowered to make?
- **Who** should do it? Consider the following:
    - Capabilities, strengths and weaknesses
    - Workload
    - Skill development opportunity
- **When** does it need to be done? Deadlines? Amount of time to be committed to the effort.
- **How** do you approach working with this person around this assignment? (How much direction versus how much delegation?)

4. Performance Monitoring

Effective monitoring:

- Provides information on the individual's capabilities
- Allows for mid-course correction
- Provides an opportunity to reinforce good performance
- Ensures that the manager's stewardship responsibility is fulfilled.

The observations made during monitoring proved a basis for doing an "end of assignment" performance feedback.

5. Performance Feedback

Performance feedback is tied to agreements made during the delegating conversation. It can be "on the spot" or a planned meeting. Both the manager and the employee should have an opportunity to discuss the situation to assure understanding of the feedback and to provide a basis for future behavior.

The outcomes of effective performance feedback are:

- Reinforcement of good performance
- Agreement on areas for performance improvement, and how
- Revised work plans
- Increase in confidence of the employee or volunteer

PERFORMANCE FEEDBACK

The definition of performance feedback is to give information to a person about their performance. The performance may be related to task or to a behavior.

Feedback may be:

Positive → to reinforce good performance
Corrective → to change or improve performance

Three Elements of the Feedback Message

- Describe action/behavior – what the person did
  "When you ignored her idea…"
- Tell what the impact was on the team, the work, on you
  "…it made me feel uneasy to see her shut down…"
- Say what the result/consequence of the action/behavior was
  "…and now I am concerned that she will be hesitant to share her ideas and thoughts."

Guidelines for Giving Feedback

1. Make specific statements. Support general statements with specific examples.
2. Use descriptive rather than judgmental language.
3. Be direct, clear, and to the point.
4. Direct feedback towards behavior that the person can control.
5. Encourage others to solicit feedback.
6. Consider the timing of feedback.
7. Make sure feedback takes into account the needs of both the receiver and giver.
8. Make sure your feedback is well planned.

The Performance Management Cycle provides benefits to the organization, the manager and the individual. When done well, it provides a return on the manager's invested time and effort.

1.4.4 Effective Teamwork[5]

Effective teamwork is required across both sets of leadership and management functions – externally in building coalitions and partnerships aligned to shared strategies, and internally in getting teams of volunteers and staff to working successfully together.

The following team member behaviors and attitudes are especially important in promoting effective teamwork:

- **Openness – "Engaging in direct conversations about what is happening"**

Team members who are open are willing to deal with problems, surface issues that need to be discussed, help create an environment where people are free to say what is on their minds, and promote an open exchange of ideas. In a climate of openness, team members are able to listen and talk with each other about issues that hinder teamwork (including individual behaviors and attitudes).

Other Factors in Good Teamwork

- Commitment to shared goals and objectives
- Clearly defined roles and responsibilities
- Using the best skills of each team member
- Clear and open communication
- Agreed-to team norms, e.g. well-defined decision procedures
- Balanced participation
- Awareness of the group process
- Good personal relationships
- Open appreciation for the positive behaviors of others
- Recognition and celebrations of success.

- **Supportiveness –"Getting the best out of others"**

Team members demonstrate supportiveness by such actions as helping others overcome obstacles or "giving someone the benefit of the doubt." It is the desire and willingness to help others succeed and involves putting the team's goal above any individual agenda, and being easy to work with. Being supportive is not passive acceptance of whatever might be going on, but active attention to doing what needs to be done so a program or service can be successful. Team members appreciate and acknowledge the contribution that others are making to the team's progress.

Collaboration requires openness supportiveness – the ability to raise and resolve the real issues standing in the way of a team accomplishing its goals, and to do so in a way that brings out the best thinking and attitude of everyone involved.

- **Action Orientation – "Just do it"**

Effective team members make a deliberate effort to make something happen. This means that the team member is willing to push, to suggest courses of action, to be willing to experiment, to

[5] Adapted from: "When Teams Work Best" by Frank LaFasto and Carl Larson.

try something different, and to encourage others to take action. There is a distinct difference between an action approach – a deliberate effort to make something happen – and a passive approach that favors waiting and hoping that others will do something about the problem or opportunity at hand.

- **Positive Personal Style – "It's all good"**

Finally, effective team members have a positive personal style and are energetic, optimistic, engaging, confident and fun to work with. It does not take many team members who are cynical, defensive, and are generally hard to work with to seriously depress the emotional energy of a team. What an individual says can send an "emotional ripple" across the team – positive or negative. Negative ripples can have a serious impact on team performance.

CSO Leadership and Management

"If the organization is run by *waria* then they will be able to get a maximum result," explains the director in response to a question about how they manage and lead the CSO. She explains that before the CSO was established, there was an organization intervening in *waria* lives that did not involve *waria* in the delivery of services and they had minimal success. The CSO's particular success is in large part due to the peer-based human resources and people management approach of their leadership. The CSO director describes this system in detail: first, they employ a careful recruitment and orientation system that includes interviewing and group training.

The director facilitates a weekly meeting for all the field workers, VCT counselors and case managers involved. In that meeting each reports their progress for the week. They share problems they've experienced and brainstorm solutions, supporting each others' work and building contingency plans. In this process they may role play scenarios in which a client provides a reason for not attending the clinic such as "I am healthy. I don't need to go to the clinic." They work together to develop responses to these scenarios that will motivate *waria* to attend health services. They discuss access to condoms, lubricants and HIV information and adjust their systems accordingly. Each Friday, activity reports from each worker are collated, presented and cross-referenced. "The number of *waria* clients that outreach workers report they accompanied to a clinic should be consistent with the number of clients the VCT Counselors report they received and all of these are compared to weekly clinic reports," the director explains.

Additional Resources

USAID SUM Program publications (Note: At this time, these are only available in Bahasa Indonesia):

- *CSO Strategic Planning "How To" Module*
- *CSO Program Planning "How To" Module*
- *CSO Human Resources Management "How To" Module*

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2. Mobilizing the HIV Response

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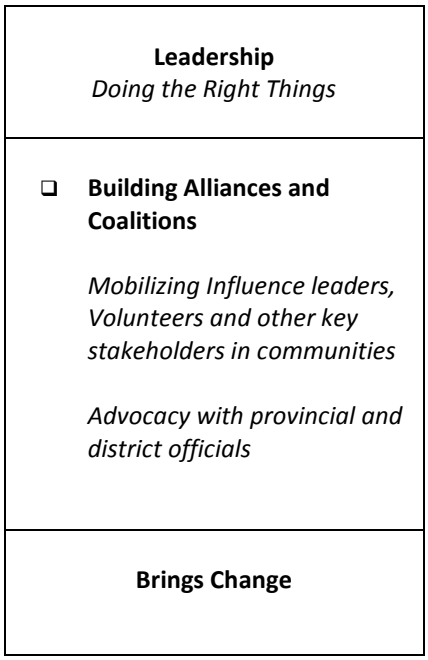
2.1 Introduction

Mobilizing the HIV Response is included in this manual as a separate module so that it can be easily pulled out and used with specific audiences in presentations and training sessions. It focuses on:

- Strategies for mobilizing most-at-risk populations; and
- Strategies for mobilizing volunteers.



2.2 Mobilizing Most-At-Risk Populations

2.2.1 What is Community Mobilization?

Individuals are members of a range of communities that can be defined by the places they live, their religion, the people they work or study with, their preferences, and their behaviors. Communities act together when they identify a shared concern or common need in which they need to mobilize to in order to create shared benefit.

The International HIV/AIDS Alliance describes community mobilization as an approach in which a community takes the lead and determines the nature of their response to a shared concern and where members within that community take responsibility and are active and influential in shaping plans and taking action.[6]

The Alliance's model of community mobilization emphasizes collective planning and action and communication and education in which community members keep each other informed and share their knowledge and skills.

2.2.2 MARP Networks

The term 'community' remains contentious when applied to MARPs, with many critics highlighting the ways in which MARPs are *not* communities of people in the standard sense. Nevertheless, community mobilization as a technique for empowering MARPs to pursue HIV health can be very effective because MARPs *do* gather and form social networks which they use for support and solidarity. These networks can be resources for collective action.

[6] HIV/AIDS Alliance, *All Together Now*

MARPs networks form because the individuals within them share similar experiences related to their gender identity, sexual preferences, their engagement in sex work and/or because they inject drugs. These individuals find that they share experiences in common and many of these experiences are unacceptable in the broader society. Because of this, MARPs networks often develop a shared language to describe their experiences: words, phrases, signs and signals that indicate their membership in the network and their understanding of the issues affecting them. This language is used to signal membership of the group to each other. Members may also develop a shared 'culture' that includes a set of agreements about how they speak, dress, behave and support each other. They may have shared ways of seeing the world and people in their world. These codes and viewpoints vary from group-to-group and from place-to-place.

2.2.3 Identifying the Places Most-At-Risk Populations Gather

This module introduces the process of *mapping*. Mapping involves drawing on paper the places where MARPs gather in a district. An organization can do this by seeking advice from staff, volunteers and people outside the organization. If an organization has not done so previously, then developing a 'map' of the places where MARPs gather is an important step toward understanding how MARPs use and interact with the spaces and institutions around them.

An annual mapping exercise can help an organization stay up-to-date with the changing places where MARPs congregate and the institutions with which they engage. Mapping can assist in the design and targeting of appropriate services to reach MARPs in the local area. Mapping has been used to understand the geographic picture of MARPs activity, to estimate the size of a particular MARP network, and to design targeted and effective services.

The adjacent box describes a mapping workshop. Note that special care will need to be given to invitees (e.g., other government sectors) if you are trying to obtain sensitive information about where most-at-risk populations gather.

Mapping Workshop

Goal: To produce a 'map' of the places MARPs gather, access services and engage in the places and institutions in your district.

Invitees: Staff, volunteers, members of MARPs networks, local government, clinic and hospital staff, other government sectors, and other CSOs.

Facilitate the Workshop: Ask a set of questions and 'draw' the responses on flipchart paper…

- *Where are MARPs networks meeting for social contact and for engaging in business together? [Map it.]*
- *Where are MARPs going for health and Welfare services? [Map it.]*
- *Where are MARPs in these networks being arrested and incarcerated? [Map it.]*
- *Are these places accessible to us?*
- *Are there risks in providing services at these places? Could we deliver services?*
- *What processes should we follow, e.g., permissions required?*
- *Who would we need to talk to?*
- *Who else could help us?*

Report Findings: Complete the map and distribute it to partners. Use the map to develop a plan for the provision of services to the MARP you are serving.

2.2.4 Design and Target Service Delivery

Once the CSO has developed a map, its staff and volunteers can drive or walk through these areas to add to the understanding of the sites and the populations meeting at these places. It is possible to initiate discussions with MARPs there, determine who is attending regularly, and scan for security threats or other obstacles.

The following two-step process is suggested for designing and targeting service delivery:

Step 1 – Team discussions on the next steps required

- Determine the priority places that MARPs meet and how the CSO might deliver outreach to these sites. You can now:
  - *Target your services to the places MARPs are meeting*
  - *Liaise with officials who are undertaking surveillance or providing services at these sites on a regular basis*

- Recruit MARPs at these sites as volunteers, as service providers, and as new leaders in the HIV health response. You can now:
  - *Identify individual MARP who are interested and motivated to participate in designing and delivering services.*
  - *Assess the skills of MARP champions and deliver training to groups of MARP to build their knowledge of HIV and their skills in service delivery, advocacy and leadership.*

- Determine the clinics and hospitals MARPs are attending. You can now:

Mapping

The *waria*-led CSO educates their outreach staff and volunteers by providing knowledge about HIV and STIs, discussing the characteristics and lifestyles of *waria*, the right times to deliver outreach to *waria* and how to establish and maintain trust and mutual respect between outreach workers and their clients.

Field workers develop a standard 'routine' for their communication with clients that may include initially attending a new area, introducing themselves to the senior *waria* at these sites and working closely with them to access other *waria* in the area. They explain why they have come to the site and they listen to the concerns of the individuals and groups there. They provide condoms, lubricant, HIV information, addresses and telephone numbers of local services and they arrange to meet again with as many *waria* as possible.

The CSO also trains their outreach staff and volunteers in data collection processes for outreach and provides them with instruments for reporting field activity. The CSO undertakes mapping exercises using their outreach teams who formally identify and prioritize the popular sites across the city where *waria* congregate. Through this mapping they aim to keep track of the environments where *waria* congregate, when these sites

- *Liaise with key practitioners at clinics and hospitals where MARPs are accessing services. Start with the easiest sites and identify practitioners who are supportive of MARPs.*
- *Develop formal and informal agreements to deliver services at these sites*

- Determine the local police, rehabilitation centers, and correctional facilities with which MARPs have contact. You can now:
  - *Liaise with these sectors and facilities*
  - *Work with officials at these sites to seek agreement to provide services there. Start with the easiest sites and identify authorities who are supportive of MARPs*
  - *You can advocate for policy and legislative changes to improve the situation for MARPs*

Step 2 – Identify entry points to district-level services and systems, and involve MARPs in liaising with these sites

Completing a series of tables can help identify the key learnings from the mapping exercise and clarify the next steps in selecting and liaising with key contacts at these sites. The tables describe:

- The priority sites where MARPs gather, where services might be provided, and where MARPs champions might be identified

- The priority clinics and hospitals that MARPs utilize, commonly accessed services and key practitioners

- The priority police stations and rehabilitation and correctional facilities where MARPs have contact with the authorities and could become entry-points for the CSO.

The tables below prompt you to list the priority sites, clines and hospitals, and police, rehab and correctional facilities.

Targeting the places that MARPs gather	**No**.	**Priority Sites where MARPs gather** (list priority sites that you identified)	**No.**	**MARPs Champions at these sites**
	1		1	
			2	
	2	Etc	1	
			2	
Targeting clinics and hospitals where MARPs access services	**No**.	**Priority Clinic and Hospital** (list priority sites that you identified)	**No.**	**MARPs Champions at these sites** (list practitioners who are open to and supportive of MARPs)
	1		1	
			2	
	2	Etc	1	
			2	
Targeting police, rehab and correctional facilities	**No**.	**Priority Police, Rehab, Correctional Facilities** (list priority sites that you identified)	**No.**	**MARPs Champions at these sites** (list authorities who are open to and supportive of MARPs)
	1		1	
			2	
	2	Etc	1	
			2	

2.2.5 <u>Involving MARPs in Design, Delivery and Evaluation of Services</u>

Involving MARPs in designing, delivering and evaluating services helps to ensure:

- Trusting and positive relationships with MARPs
- Useful services directed at what MARPs need
- A supportive environment that encourages health seeking behaviors

When MARPs are provided services from their peers they feel that the organization is part of their own network and therefore can be trusted. When MARPs are engaged in designing and evaluating services the greater the likelihood that the services are meeting their needs.

The following questions will enable the CSO to better understand the way in which they do or do not engage MARPs in the design, delivery and evaluation of services:

- Does the organization currently involve MARPs in designing, delivering and evaluating services? Yes/No.
  - *How could the organization improve in this area?*
  - *What would the organization need to do?*

- Does the organization currently provide education to MARPs to develop their skills to participate in the district-level response to HIV? Yes/No.
  - *How could the organization improve in this area?*
  - *What would the organization need to do?*

- Does the organization employ MARPs as volunteers, as paid staff and/or as managers in its MARPs programs? Yes/No.
  - *How could the organization improve in this area?*
  - *What would the organization need to do?*

- Does the organization recruit MARPs to participate in its governance structures? Yes/No.
  - *How could the organization improve in this area?*
  - *What would need to happen in the external environment to help this?*
  - *What would the organization need to do?*

2.2.6 Improving the Quality of the Relationships with MARPs

The nature of the relationship between a CSO and a specific MARP groups is critically important in determining the effectiveness of programs and services. The quality of the relationship can be determined by following eight areas:

1) Responsiveness – how open is the organization to issues affecting MARPs, and how quickly it responds to these issues.
2) Integrity – how fair and just is the organization is to MARPs (measurement of trust)
3) Dependability – perceptions of reliability (also measurement of trust)
4) Competence – how skilled and capable is the organization (also a trust measurement)
5) Commitment – how loyal and dedicated is the organization is to MARPs
6) Satisfaction – how satisfied MARPs are with their relationship to the organization
7) Empathy – how understanding and accepting is the organization
8) Effectiveness – how helpful are the organization's services are to MARPs.

Focus groups offer a qualitative way to assess the quality of the relationship. A written questionnaire (completed anonymously) based on the above eight areas offers a quantitative approach.

Once an organization understands the nature and quality of its relationship with MARPs, it can set out to improve these relationships. The table below provides an action planning format.

Improving our relationship with MARPs	**No.**	**Categories**	**No.**	**List two actions you'll take to improve**	**By when?**	**Who will lead?**
	1	Responsiveness	1			
			2			
	2	Integrity	1			
			2			
		Etc.				

2.3 Mobilizing Volunteers

Volunteers provide the backbone of many HIV programs and services throughout the world and the experience in Indonesia is no different. Volunteers can easily reach into subpopulations most affected by HIV and help individuals and communities respond to HIV and care for PLHIV in their midst.

There are many advantages to enlisting volunteer support in the response to HIV:

- Volunteers from within the communities most affected by HIV understand their own communities and can reach people who do not trust government or mainstream agencies.
- Mobilizing volunteers can increase the reach of the CSO's program into communities, because volunteers can be enlisted over a wider geographical area.
- Volunteers know the particular language and cultural norms of their community and can tailor prevention and care messages to better

Volunteers Bring Sustainability

One *waria* CSO says its most important characteristic is that it is largely operated by volunteers. They see this as their strength and a key element that has made them sustainable. While other CSOs have collapsed due to lack of funding, this CSO continues providing basic help and support to most-at-risk populations regardless of the decisions of funders. If they receive no HIV funding at all it does not stop them from providing HIV information, referral and support, and maintaining strong partnerships with other community-based organizations.

meet people's needs.

- Training and supporting volunteers from within a community can build the capacity of the community to manage their own programs and respond to other issues.

It is important to understand that volunteer labor is not free or cheap labor – to make volunteer programs work effectively takes extensive time and financial commitment, because quality relies on the provision of training, supervision and support and on a framework of policies and procedures that promote a high standard of intervention across the program.

Key points to consider:

- Effective volunteer programs are based on good volunteer selection, training, supervision and support.

- Like paid staff, volunteers need a clear job description, capacity development and performance management.

- Attention needs to be paid to finding ways to value volunteers in a program so that they are not treated as 'second-class citizens' in the program.

- Volunteers get bored too – they need a career path within the organization and ways to develop their skills and change the nature of their work.

- A clear framework of policies and procedures will ensure that volunteers understand the limits of their role, how they can seek help and assistance, and what to do as issues arise in their work

- Documenting volunteer effort and the outcomes of their work is an important part of monitoring and evaluation.

The USAID SUM Program module on mobilizing MARPs includes a helpful framework for designing a volunteer program, including:

- Key questions to begin with
- Identifying sorts of things volunteers might do
- Identifying where volunteers might be found
- Recruiting and selecting volunteers
- Training, supervision, support and incentives for volunteer
- Evaluating and improving volunteer services.

2.3.1 Designing a Volunteer Program

In designing a volunteer program, the key questions to begin with are:

- What are we trying to achieve in the population we are working with? (What problem are we trying to solve?)
- What have they told us about their needs?
- What roles could volunteers play in meeting these needs?
- How could our volunteer workforce be organized? Who would support them?

Designing a volunteer program is not as simple as sending a few volunteers into communities to raise awareness about HIV. Considerable thought should be given to the particular problems that need solving and to the design of the volunteer program – to ensure the program and volunteers will be addressing the stated needs of the community.

People of course need to know about HIV, but they also need help to find ways to respond to the risk and impact of HIV over time. For programs to work over the long-term, we need to understand what a long-term connection with this community would look like. For example, we need to know:

- Exactly what prevents people in the community from responding to HIV – is it a lack of knowledge, a lack of means, a lack of power? All three? How could this community be assisted to address these constraints?
- Who would they listen to about HIV? How would these messages need to be packaged? What else would need to be in place to ensure that they get what they need?
- Who is our potential volunteer workforce? What skills do they already have? What do they need from us?

2.3.2 What Do You Want Volunteers to Do

Make a list of the tasks that you think volunteers are most suited to do in your program. Remember, it is not a money-saving exercise. You are trying to decide what jobs are BEST done by a volunteer workforce. Jobs might include:

- **Outreach to communities at-risk and affected –** for example, training current or retired sex workers to go out to streets and hotels where sex workers work and provide information and support for safer sex.

- **Connecting communities with health services** – for example, training MSM to go out and engage with other MSM and help them access friendly and supportive STI services

- **Supporting people with HIV** – for example, visiting PLHIV on ART in the community and helping them to maintain a connection with their health services.

2.3.3 Where Will You Get Volunteers

Think long-term not short-term. You are more likely to leave the community with increased skills and resources to grow and meet their own needs over time if you choose volunteers from within the population. Working with volunteers *from the community* and helping them to design and develop lasting organizations and structures is a more sustainable model than choosing volunteers from outside the population and having them work within a population they know little about or have little permission to operate within.

Therefore, your volunteer workforce should come from within the key populations and you need to design a program that makes best use of the skills, motivation and time of these volunteers.

Choosing Volunteers

Examples of helpful personal attributes:

- Honesty
- Sensitivity towards others
- Communication skills
- Trustworthiness
- Motivation
- Acceptance of differences
- Ability to work with others
- Reliability

2.3.4 Recruiting and Selecting Volunteers

Choosing volunteers is important. Don't just accept anyone who wants to help. Think about what you need these volunteers to do – they will be moving through populations engaging with people about sex, drug use, HIV illness and so on. They will need a particular set of personal attributes. (See adjacent box.)

Make up your own list of desired volunteer attributes in consultation with the population you are working with. Think about how people can demonstrate these attributes – the behaviors associated with each. Most people think that they have these characteristics, so how are you going to assess them?

Some programs use individual interviews; others interview batches of prospective volunteers in groups so that they can see how people interact. See what works best. Use your existing experienced volunteers to interview new volunteers. They are often good at assessing people.

In the selection process, make sure that the applicants get information about what will be expected of them as volunteers, so that they are making an active and informed choice to be involved. If they are selected, ask them to commit for a specific people, for example 12 months. Treat the people you don't select with respect and explain why they were not selected.

Once selected, help your volunteers succeed by providing training, support and supervision (see 1.4., Human Resources Management). Volunteers require the same as paid staff – sometimes more, because you are relying on their motivation and care for their community to maintain their effort.

2.3.5 Volunteer Programs – Supervision and Support

Volunteers need supervision and support for the work that they are doing. Many programs set up structures that cluster volunteers into groups with a group leader (paid or unpaid) who receives additional training to provide supervision and support. These might be geographical groups, or groups attached to particular tasks or sub-populations. As your organization grows, you will need to put in place a hierarchy that ensures that every volunteer has immediate access to someone who can support them as they carry out their work.

2.3.6 Incentives for Volunteers

Attracting and keeping volunteers can be difficult, particularly in environments of high unemployment and poverty. Most adults need a source of income to pay for food, housing and other essentials of life. Think about how your program will attract and keep volunteers in this environment and design a set of incentives or support measures that will assist. Consult with your potential volunteer pool about what these might be. They are usually not cash, but might include, for example, access to skills training – not just specific to their volunteer work, but also in other areas that might help them with future employment, such as: English language; computer skills; crafts or trade skills; technical writing skills; and qualitative research skills.

If appropriate, build in a career path for volunteers, e.g., they start as a volunteer, receive training to supervise other volunteers, and perhaps eventually get a paid position in the organization or another organization that uses volunteers.

Approaches to Volunteer Supervision and Support

- ***Briefings before outreach***: Brief volunteers on what is currently happening in the locale or population.
- ***Visit volunteers***: Observe their work and communication with peers.
- ***Weekly group meetings****:* Allow volunteers to share success stories and voice concerns and problem. Group leaders are able to give recognition, build skills and address problems as they arise.
- ***Give feedback****:* Give volunteers regular positive and constructive feedback – based on your observations and what is solicited *f*rom clients and service providers.

Supervision of Volunteers

Each CSO staff member and volunteer signs a Code of Conduct and agrees to engage in professional and appropriate interventions. They keep notes on individual client engagements and talk together about these and what they are learning. Each individual MSM is different, with different concerns and health issues, and each has needs for different kinds of information, support and follow-up. They provide condoms and lubricant and advice on how to use them correctly, as well as information on where to get STI and HCT services.

2.3.7 Evaluating and Improving Volunteer Services

It is essential to develop mechanisms that allow you to see what impact your volunteer service is having on the population you are working with and lets you better tailor what you are doing better to the need of the population. This can be done in several ways, such as:

- Start with a clear set of goals and objectives so that you can see what problems or issues you are trying to influence.
- Set up a clear, concise and user-friendly documentation, monitoring and evaluation system (right from Day 1 of your program) that allows you to collect and analyze the data and information you need to guide your program and demonstrate what it is achieving.

- Include evaluation methodologies (see references section for *Most Significant Change* and *Appreciative Inquiry*).

- Prepare regular reports and share these with donors, clients and volunteers as a way of improving your services.

- Have formal feedback mechanism in place so that clients (peers) can tell you what they think of the program and how it can be improved.

- Encourage the genuine participation of people from the population you are working with in the decision-making structures of your program.

Additional Resources

For more on mobilizing strategies for MARPs see the following publications:

- USAID SUM Program, *CSOs: Mobilizing MARPs in the Response to HIV "How-To" Module*
- HIV/AIDS Alliance, *All Together Now*
- Rick Davies and Jess Dart. *Most Significant Change.* (http://www.mande.co.uk/docs/MSCGuide.pdf)
- David Cooperider, Diana Whitney and Jacqueline Stavros. *Appreciative Inquiry Handbook, 2nd Edition.*

2.3.8 Next Steps

Seek out advice and approaches from other experienced programs:

- Who is already working with volunteers or already working with the population you want to work with? Can they help you identify volunteers with the personal attributes you seek)?

- What policies and procedures are they using? Can they be adapted to what you want to do?

- Is there a national body that provides guidance on volunteer issues? What can they offer?

- What about the population itself – how is information transmitted within this population?

- Is there support available? How is it structured? How can it be accessed?

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3. Advocacy

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3.1 Introduction

Leadership
Doing the Right Things

- **Building Alliances and Coalitions**

  Mobilizing Influence leaders, Volunteers and other key stakeholders in communities

  Advocacy with provincial and district officials

Brings Change

Advocacy is included in this manual as a separate module so that it can be easily pulled out and used with specific audiences in presentations and training sessions. It focuses on:

- Advocacy in the district-wide HIV response
- Strategies for effective MARPs-based advocacy

3.2 Stigma and Discrimination

The bottom-line: HIV interventions *cannot be fully effective* in an environment in which those at risk or living with HIV face stigma and discrimination.

Here are some real examples from recent interviews and focus groups[7] with CSO leaders and representatives of most-at-risk communities:

- *A CSO volunteer describes the difficulties she experiences when assisting female IDUs at hospitals. Clinical staff members she says view IDUs as criminals who are engaging in immoral behavior and who do not deserve services and support. "They will not provide services to IDUs living with HIV," she says, "because they don't want the equipment to be contaminated."*

  A focus group participant who is an IDU described his feelings when a clinical staff member accuses him of stealing a possession that was misplaced.

- *A CSO program manager described a situation with Puskesmas clinical practitioners who had little experience with MSM. They openly expressed views that are homophobic and they had no awareness of the issues affecting MSM. The doctor at the Puskesmas said he did not feel comfortable with MSM and did not want to assist them. He said "these men are sissies, effeminate, and not real men."*

  > "*These men are sissies, effeminate, and not real men." Puskesmas* doctor

- *One waria explained the difficulties living in a 'third space' between male and female. She says she is lucky because her family is accepting and does not discriminate against her. The problems that she encounters are in the community and in the workplace. She*

[7] Interviews and focus groups with approximately 100 people were conducted during August-October 2010 by the USAID SUM Program. They included CSO, provincial and local government, and MARPs leaders in Jakarta, Surabaya and Malang.

was a teacher and was not allowed to teach dressed as a woman. She decided to give up her job and work instead in a beauty salon.

Sometimes she says waria are discriminated against by family and the community and are fatalistic. She tries to motivate friends that even if you are waria you are a good person. But the media projects negative images of waria, which create cynical attitudes in the community. Religious practice is important for some waria so they go to the mosque, to the church, and pray, but ironically the people do not understand why you go to the mosque or the church when you are waria.

- *In one focus group participants talked about a standard district hospital practice experienced by HIV patients. No matter what their complaint or symptom they are placed in the tuberculosis ward. People with HIV are at increased risk of tuberculosis infection.*

  Others interviewed shared experiences in which, when identified as having HIV, they were made to wait outside the reception area in the corridor, and on plastic sheets or on a plastic chair. They are asked to purchase their own instruments for dental care. Some say they would rather die than go to the district hospital for a serious illness.

  The leader of a CSO, who is a member of a most-at-risk subpopulation, expressed dismay about the low level of power and influence the CSO has with local government. They are not included in government-led HIV planning meetings, which they attribute to stigma and discrimination. "We have no equal place at the table," he says.

3.3 Advocacy – A Critical CSO Leadership Role

As these real examples illustrate, HIV programs and services *cannot be fully effective* in an environment in which those most-at-risk or living with HIV face stigma and discrimination. Stigma and discrimination exist in the personal beliefs and attitudes of people (provincial and local government officials, health service providers, neighbors and even family) and they are also pervasive in national and local laws and policies.

As a result, people living with HIV commonly internalize this social shame and blame, anticipate negative reactions from others, and resist coming forward for essential services and medical treatment.

The ***Gay, Waria and other MSM National Network*** – GWL-ILA – aims to build the knowledge of Gay, *waria* and other MSM about their rights, and also the obligations of "duty bearers" such as the police, Satpol PP, health workers, prison officers and others. In 2009, GWL-INA became a member of the National AIDS Commission.

Advocacy to reduce stigma and discrimination is a critical leadership role. In several of the above real examples, CSO leaders are currently working with *Puskesmas* staff to challenge negative attitudes and promote service provision without judgment. They are training and mentoring clinical staff about sexual preferences and behaviors and the most recent

recommended packages of interventions and friendly service guidelines for injecting drug users, female sex workers, men who have sex with men and *waria*. There are also examples of CSO leaders training and mentoring the police – to increase their sensitivity about most-at-risk populations in their communities and ways they interpret and enforce laws at the local level (see adjacent box).

One area identified by many CSO leaders that needs greater advocacy is with local government. CSOs are asked by local governments to provide reports and other related information about most-at-risk populations, but many CSO leaders express disappointment that they are not invited to HIV-related meetings and that they rarely receive feedback about their reports.

3.4 Using Evidence to Inform Advocacy

"Where is the evidence?"

CSOs working with most-at-risk populations cannot run away from this question. It is a core question asked by policy makers and potential funders. Many CSOs – from years of experience – possess rich anecdotal evidence; however, if these evidences are not documented, they are deficient of the credibility needed for advocacy purposes.

The evidence-based approach to advocacy is simply defined as providing the necessary "proof" to verify that a problem exists and that we need to convince our partners and stakeholders to collectively respond and find possible solutions to resolve the problem.

Advocacy with the Police

Example 1) From the perspective of police, sex between men has been considered morally wrong if not illegal. For many years it was not unusual for "hotspots" in Malang like sports stadiums and parks where men meet for sex to be raided by police and the men meeting there to be detained or harassed.

To address the problem, some CSO members approached the police department to hold a meeting to discuss the situation. It was important that at first they approached individual police officers that they knew, such as relatives or friends who were police, to seek their advice and support in the first instance. Over time they have managed to establish an agreement with the police that they would not detain or harass MSM at hotspots. Now, when police find men having sex in a public place they will move them on rather than arrest or harass them.

Example 2) Police raiding sites where *waria* engage in sex work remains a barrier to the distribution and use of condoms and lubricant in *waria* sex work. *Waria* outreach workers can also be arrested for carrying condoms and may be confused by police as sex workers rather than HIV outreach workers. One *waria* CSO described its experience of police harassment and arrest. Two of its *waria* staff were arrested. They were able to obtain legal support and advocacy from a rights organization and obtain and audience with the police. Since then, the police inform the CSO if there will be any raids and there have been no more arrests.

The more information and data we possess, the more rational and precise our advocacy strategy will be. It is also useful to identify the target audience(s) for each advocacy activity, because people are influenced by different types of data or different presentations of data.

For example, epidemiological models and scientific journals are appropriate for public health practitioners and senior policy makers; whereas the MARPs community will appreciate case examples, best practices and other community-led documented evidence. Law enforcers will require a totally different set of evidence. They will act on legal evidence, so documentation on violations against groups and individual rights will present compelling arguments and evidence for action.

3.4.1 Methods for Producing Qualitative and Quantitative Data

It is possible to produce both qualitative and quantitative data at the community level. Qualitative data are documented stories collected from interviews conducted via focus group discussions and in depth interviews. This manual uses real case example and illustrations, which is an example of qualitative evidence.

Qualitative data provide powerful insights to the lives of MARPs populations, dispel common stigma, promote better understanding of their vulnerabilities and helps to identify issues of importance to a particular target group or community.

Quantitative data can be counted or quantified to give numeric estimates and generate conclusive findings. They can tell us how many people of different demographic characteristics live in the target area, verify the number of times something happens, or document differences between things that can be measured in numbers, for example, the prevalence of HIV amongst a population of IDU, FSW and MSM.

Evidence can be used to:

- Identify specific issues for policy action
- Assess what policy changes are necessary
- Choose advocacy goals and objectives
- Directly influence policy-makers and program planners
- Inform the mass media, the community and other important people about MARPs-specific situations and lobby for change;
- Offer counter positions or arguments opposing specific methods of preventing HIV within among a specific community
- Change attitudes of the public towards MARPs and establish an environment in which HIV prevention can be implemented
- Challenge myths and assumptions about what works in HIV prevention and generate debate on strategies or policies that have been shown to be ineffective
- Confirm that HIV prevention is working in a specific locality

Rapid assessment and response methods can quickly provide information. The text boxes on RETA and RNM (see following page) are two methods used in the Indonesia HIV response. These methods are used to examine:

- The nature of problems experienced by the community and the factors influencing them at various levels.

- The adverse health consequences of risk behaviors, including the transmission of HIV and other communicable diseases.

- The resources that are or might be available to respond to drug and HIV/AIDS problems.

- Interventions which are socially, culturally, religiously, politically and economically appropriate and accepted.

Rapid assessment methods are:

- Fast, pragmatic and cost-effective

- Use multiple indicators, existing data sources and rapid methods to collect any new data that is needed

- Establish a quick understanding that is refined based on further evidence; use the knowledge and opinions of a wide range of people

- Provide relevant results for programming and policy development

Resource Estimation Tool for Advocacy (RETA)

RETA is a Microsoft Office Excel-based costing tool that helps calculate the resources needed for scaling up coverage of key HIV services. For specific most at risk population groups. RETA allows for basic resource needs estimations and is user friendly to program planners, such as advocates and managers employed by CSOs and other organizations. A network of local CSOs may work together to collect the information needed to use RETA and later consolidate their efforts with the government to advocate for increased resources for HIV prevention programs.

RETA is based on the idea that the delivery of a Comprehensive Package of Services (see Diagram 1 in the opening section of this manual) is the "gold standard" approach for HIV prevention (though such a package has to date only been defined for men who have sex with men and injecting drug users). RETA can generate a financial analysis that compares current services and levels of financing against the projection of resources needed for future HIV program plans and targets. In sum, it highlights where there are gaps in funding. The data required to use RETA as a costing tool are not complex or difficult to obtain – mainly four types of data: 1) population size estimates, ideally by locally defined sub-population, 2) HIV prevalence and projections (to estimate HIV+ proportion of the population who need care, support and treatment services), 3) HIV programs and services cost / budget data based on actual existing services, and 4) current and anticipated HIV programming and resource allocation figures.

Using this information, RETA calculates the resource needs at a local, provincial or national level to scale up coverage in a package of services over a five-year period. This can be an integral part of strategic planning for HIV programming and form the basis of advocacy efforts to increase funding for HIV programs for men who have sex with men, female sex workers or injecting drug users.

RETA is available in Bahasa Indonesia. For more information about RETA, see *The Resources Estimation Tool for Advocacy (RETA) User's Guide,* available from USAID SUM Program.

Resource Needs Model (RNM)

The Resource Needs Model (RNM) is another costing tool used for costing national HIV programs – the total resources needed on the national level for prevention, care, and orphan and vulnerable children. Similar to RETA except with a larger scope, RNM can assist national-level strategic planning efforts.

The model contains three sub-models: 1) ***Prevention***, which calculates the cost of specific prevention interventions and allows the user to specify up to five additional priority populations such as prisoners, migrants, or truck drivers; 2) ***Care and treatment***, which estimates the cost of care and treatment programs; and 3) ***Mitigation***, which calculates the cost of interventions to support orphans and vulnerable children (OVC). Each sub-model has three main elements in the methodology: 1) *Population target groups; 2) Unit costs; and 3) Coverage or access targets.*

The major steps involved in using the RNM are as follows:

- Form a national team to implement the model *(*multi-disciplinary and representing government, civil society, private sector and donors).
- Collect and enter data specific to RNM on socio-demographic variables, health systems, HIV prevalence and condom use, and the costs of prevention and care programs
- Conduct workshops on resource needs (interactive sessions where decision-makers validate the assumptions, such as coverage targets and certain unit costs).
- Follow-up on workshop outcomes (e.g., as part of the strategic and planning and budgeting process).

The RNM is supported by an epidemiological model called Spectrum; which allows projection of disease progression. These manuals and the Spectrum program can be downloaded from the web site of the Futures Institute at: www.FuturesInstitute.org

3.5 Developing Advocacy Plans and Strategies for Action

An noted above, once an organization or a network of organizations has decided on a priority issue for advocacy, it needs take an evidenced-based approach to information gathering to create a compelling and credible platform for advocacy. Specific and measurable objectives of the campaign can then be formulated.

Steps in Developing an Advocacy Strategy

1. Select the issue or problem you want to address.
2. Analyze and research the issue or problem.
3. Develop specific objectives for your advocacy campaign.
4. Identify your targets.
5. Identify your resources.
6. Identify your allies.
7. Create an action plan.
8. Implement, monitor and evaluate.

Not all outcomes of an advocacy campaign result in tangible change. Therefore, it is essential to focus the campaign on the people who have the greatest capacity to respond and to bring about the changes you are seeking. These are usually people with the power to make policy or program decisions.

Use your allies. Your campaign will have a greater chance of succeeding if you can identify other organizations and individuals with similar interests. Include them in your planning and implementation process. Potential allies can include:

- Other CSOs
- Other components of civil society – supportive unions, religious institutions or leaders, and community leaders
- Supportive or sympathetic journalists
- Supportive government officials willing to lobby from inside

Develop an action plan, which consists of a specific set of activities and timelines to support the objectives of the campaign. Identify persons responsible for each set of activities and develop a reporting system for monitoring.

Implementing an advocacy campaign comes with risks. Anticipate these potential risks and develop contingency plans. Contingency plans may include press releases, appointing a key representative whom you can mobilize urgently when there is a need for damage control. Be ready to temporarily cease the campaign to reflect on your strategies if the outcome desired is not forthcoming.

A monitoring and evaluation system should be in place to keep an eye on the progress of the campaign. Monitoring and evaluation allows you to reflect on the effectiveness of your strategy and change the modality if need be. It is also useful for future advocacy campaigns when you are able to demonstrate the success of your advocacy plan and strategies.

3.5.1 Policy Briefs and Position Papers

In writing policy briefs and position papers to advocate for legislation or policy changes:

- Involve people who are affected by a particular law or policy.
- Clearly state the position or opinion of the organization (or a coalition of organizations) about the law or policy.
- Write specifically for the understanding of those in position to make legislative and policy changes.

A policy brief or a position paper is not like a press release. Remember, the target audience is different and be prepared for opposition.

Briefing notes are also useful tools. A briefing note is written for an ally, not a target. It is similar to speaker's notes, to help someone who is speaking publicly in support of your advocacy objective. It often includes additional advice to the speaker – for example, how to answer questions, or key points to emphasize.

Policy Briefs and Position Papers

Multiple Uses

- Leave with individual decision-makers at face-to-face meetings to summarize the main points of your message.
- Send to provincial and local government departments during consultation exercises.
- Send to people in influence, in response to a policy or action, to explain an alternative or supporting position.
- Share with the media via press releases or with organized meetings and presentation.
- Summarize the resolutions of a conference or workshop.
- Visibility – shows that many different allies support your advocacy objective.
- Provide to delegates or members of a committee at the beginning of a meeting or conference whether or not you are on the agenda to speak at the meeting.

3.5.2 Influencing Local Leaders and Politicians

Community members can also have direct influence on leaders, because they are their constituency. HIV interventions for MARPs will not be successful without the political will to break boundaries and change disenabling policies. The support and buy-in of local political leaders is essential for delivery of commitments and mobilization of adequate resources for a district's HIV response. Their leadership is required to promote the elimination of HIV-related stigma and discrimination and the rights of people living with HIV and of most-at-risk communities.

The media can also be a powerful tool for advocacy, but requires careful consideration due to the sensitivities of MARPs-related issues and recognition that the media is not always supportive of populations of drug users, sex workers, MSM, and transgender people. Mass media coverage is useful for example in publicizing new research findings or the adoption of new policies at the national, regional or local level. The media is always keen to carry stories

based on new scientific evidence. On the other hand, the media is also keen to publish sensationalized stories, which causes more harm than good to HIV programs.

Sensitizing media practitioners to HIV/AIDS issues is an ongoing activity. Identifying and developing allies in the media is an asset to advocates. These allies can be called upon when an important issue needs to be highlighted. They can also dedicate special columns or features for events and major announcements, or draw the public's attention to critical developments in HIV/AIDS work.

Conversely, there are other instances where undue media attention can potentially be detrimental. These can include the opening of a drop-in center, the establishment of a needle and syringe program or some outreach activities. Too much attention can disturb program implementation and jeopardize the confidentiality of activities. In many situations, it is better to work quietly in the background so as to not draw unwanted public attention to the activities being implemented.

Another example of the potential misuse of media in advocacy work is when CSO's discontentment with government officials or institutions is made public through the media. CSOs may decide to issue a press release, for example, when the government withdraws support for MARPs programming, only to find that the expected public support did not happen. Government departments and institutions usually do not take kindly to public "shame and blame" and may even feel threatened. CSOs and local government future collaboration and funding for programs could be damaged, which will ultimately impact on the communities.

Make journalists an audience of advocacy before deciding to include mass-media coverage as an advocacy method. It is also important to develop your media skills, such as how to write a media release and media interview tips and techniques.

The media are well placed to educate and inform people by providing accurate information about HIV/AIDS and sexual health. The media can help to dispel the myths and fears that surround HIV/AIDS and help your organization achieve its mission, aims and objectives. Once people are informed and educated about issues, they can be mobilized to take action.

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4. Financial Management

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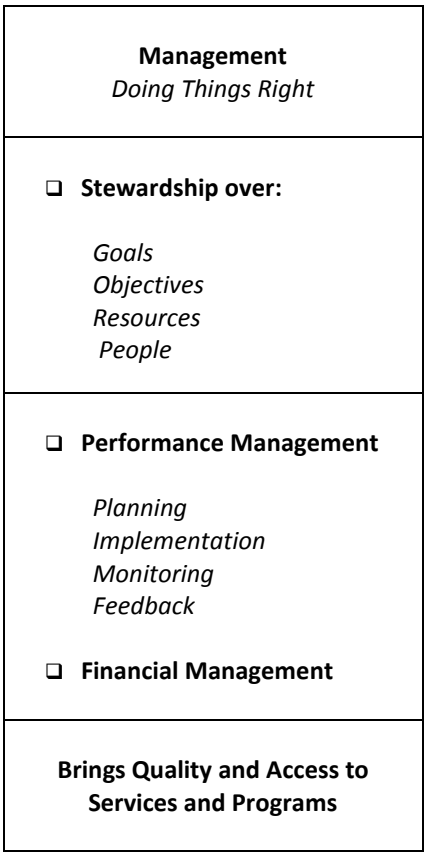
4.1 Introduction[8]

The purpose of this section is to highlight what is required to maintain the books and records of a non-profit organization with basic bookkeeping needs. It looks at the basic requirements for establishing an accounting function, from implementing an accounting system to generating financial statements. Best practice guidelines are provided, covering:

- Banking
- Staffing
- Establishing a chart of accounts
- Accrual and cash basis accounting
- Budgeting
- Financial statement preparation
- Policies and procedures



4.2 The Accounting Process

Meaningful financial data cannot be produced without a mechanism to capture, record, review, summarize and report information. This entire process is called accounting.

The accounting process can be described as an ongoing, monthly cycle consisting of:

- Cash receipts and disbursements
- Accrual entry
- Closing procedures
- Financial statement preparation
- Review and analysis

The ultimate goal of an accounting system is to generate accurate and timely financial statements that provide meaningful financial data to the reader. Readers may include:

- Leadership of the organization (the governing board)
- Executive director
- Donors and lenders
- Your constituency (i.e., the public)

[8] Based on *The Complete Guide to Nonprofit Management.* Smith, Bucklin & Associates, Inc. 2000.

All financial documents, by Indonesian law, must be kept for a minimum of 10 year. If the decision after 10 years is to destroy financial records, a memo to this affect is required.

4.3 Key Steps in the Accounting Process

Opening a Bank Account

Most non-profit organizations have straightforward banking needs. They usually encompass deposits, withdrawals, and obtaining bank balances.

Staffing the Accounting Function

Small organizations can usually maintain the books by assigning the responsibility to a volunteer, part-time staff person or full-time administrative assistant. Although bookkeeping experience is helpful, it may not be required initially if sufficient guidance is provided and the accounting system is simple. This staffing approach may be appropriate for CSOs with relatively small budgets and limited check writing volume.

CSOs with larger budgets may require an accounting staff consisting of 1) a chief accountant with non-profit experience to oversee the accounting process and 2) assistance from one or two bookkeepers who may separate the accounts receivable (cash receipts) and account payable (cash disbursements) functions.

Establishing the Accounting System

The accounting system is the mechanism that facilitates the recording of transactions into (in the case of computers) or onto (in the case of a manual ledger) various files that can be used to generate financial statements. The number of transactions (deposits, checks, journal entries) determines whether it is cost-effective to automate the accounting process.

A manual system may be the most appropriate choice for a small CSO with a limited number of transactions. Some CSOs may write enough checks to warrant the purchase of a check register accounting system, whereby checks are manually recorded in a ledger at the same time they are prepared. This combination check-book-and-expense-distribution journal provides a simple way of recording receipts and disbursements while maintaining the check-book balance.

An automated system does not have to be a complicated one. There are numerous “off-the-shelf” accounting applications available. Such systems can be installed and maintained by the CSOs paid or volunteer staff. Typically, accounting packages include a general ledger, an accounts receivable subsidiary ledger, an accounts subsidiary ledger, and sometimes a payroll module.

Chart of Accounts

A chart of accounts is the account numbers your organization will use to record and report financial transactions. The chart of accounts can be very simple and easy to use as long as it is not too detailed. A separate account number is not needed for every type of revenue and expense anticipated. Ask: what is important to monitor and if this information should be specifically identified in the financial statements.

For non-profit organizations, it is recommended to report results using functional classifications, natural classifications and project classifications:

Sample Natural Accounts Table	
Natural Account Number Range	*Financial Statement Category*
1000-1999	Assets
2000-2999	Liabilities
3000-3999	Net Assets
4000-4999	Revenue
5000-5999	Expense

- *Natural accounts* are those that can be used across functional categories. Natural accounts numbers can refer to specific accounts, including both income – such as contributions, membership dues, or other income – and expenses, like those for meetings, salaries and fringes, printing, rent, telephone, and so forth.

Sample Functional Category Table	
Function Number	*Function Description*
100	Prevention and outreach
110	HIV care, support and treatment
120	Research
130	Training and capacity building
200	General and administrative
210	Fund-raising

- *Functional reporting* reflects revenue and expenses by major program and service activities, such as HIV prevention and outreach, HIV care, support and treatment, research, training and capacity building, etc.; and supporting activities, such as general, administrative, and fund-raising.

- *Project reporting* reflects revenue and expenses by specific funders, such as USAID SUM Program, AusAID HCPI, or Global Fund. This category table will assist CSOs with multiple funding sources to track revenue and expenses by funder, which facilitates meeting their financial reporting requirements.

In developing the chart of accounts, use a numbering or lettering scheme that refers first to the functional classification. Program activities and supporting activities are functions that are

usually two or three digits long. They are usually assigned numbers so that they are printed in numerical order (see above box).

Sample Project Category Table	
Project Number	*Project Description*
01	USAID SUM
02	AusAID HCPI
03	Global Fund
04	Management

Natural account numbers are usually three or four digits long and can be used throughout your chart of accounts in the appropriate functional categories. Be sure to use the same natural account numbers throughout the functional categories. It is best to use a series of numbers that group the natural account numbers by financial statement category (see above box).

The chart of accounts provides a location for posting all transactions within the general ledger. For example, in reference to the above boxes, an organization can record postage expenses for the USAID SUM Program training invitations to 7760-130-01. Or cash received can be recorded in 001-1010. Fund-raising revenue might be recorded in 4200-210-04. Both the function and the account number are used in coding transactions. The chart of accounts is important because it is the basis for generating your monthly financial statements.

Accrual and Cash Basis Accounting

In accrual basis accounting, revenue is recognized when earned rather than when received, and expense is recognized when incurred rather than when paid. The use of accrual basis accounting can produce pre-paid expenses – when goods or services are paid for in advance – and prepaid or deferred income – revenue received for goods or services that have not yet been received or performed.

Your organization, however, may determine that keeping the books on a cash basis during the year is sufficient. If your financial reporting needs are not significant and you have limited staffing for the accounting function, it is easier to record revenue when cash is received and to record expenses when disbursements are made. Conversion to the accrual basis of accounting can then be performed at the end of the year. During the year, however, it is important to be aware of expenses that have been incurred but not yet paid so as to avoid overspending your budget or altering your cash position.

Cash Receipts

The accounting process starts with cash receipts, a function common to all organizations regardless of size or purpose. In accounting terminology, cash also means funds from checks and wire transfers. When funds are received, they should be recorded by one person and deposited in the bank by another person. This segregation lessens the risk of loss or misappropriation. Documentation should be available for every deposit made. A copy of the deposit slip and copies of checks or other notations should be filed in chronological order. As

the deposits are made, code them in accordance with your chart of accounts and organize them so they can be entered into your accounting system.

Cash Disbursements

Cash disbursements include the processing of checks, wire transfers and petty cash. This function is a critical one because it entails direct access to one of your organization's most valuable assets – cash. Even if staffing resources are limited, your group must implement internal accounting controls to safeguard your funds and to ensure that disbursements are authorized and appropriate. Ideally, the cash disbursements function includes the following:

- Approve invoice for payment
- Authorize that a check be issued
- Prepare and record the check
- Sign check for vendor pick-up/wire transfer to vendor
- Reconcile bank account
- Review bank statement, bank reconciliation, and check register.

The critical internal control feature inherent in this function is that the person authorizing and signing checks is not the same person preparing the checks and recording them in the general ledger. When a disbursement is made, it must be coded and recorded in the general ledger. File a copy of the check with the supporting documentation by voucher.

Closing Procedures

Closing procedures entail a review of key asset and liability accounts. Each month, a series of accounts should be reconciled against subsidiary ledgers and other supporting documentation. It is possible that during the month, entries have been miscoded and misposted, and therefore ending balances will not be accurate. Closing procedures include the process of posting balances to the general ledger and performing an internal control, called the analytical review.

Cash is the first account that should be reconciled or "closed" as part of your organization's closing procedures. Cash can be closed by preparing a bank reconciliation and having it reviewed by someone other than the person posting the entries to the general ledger. Make sure that all account balances have support or some type of corroborating documentation that ties into the numbers on the statement of financial position. Liability accounts should also be reconciled as part of the closing process.

Budgeting

The executive director develops the annual budget and submits it to the board for approval in accordance with the organization's bylaws. In preparing the budget, first examine last year's results and this year's most recent financial information in order to identify trends and

variations from your expectations. In projecting revenues identify the most likely income sources first and period of time over which this revenue will be recognized. Fund-raising receipts, other donations, grant income, and in-kind contributions are more difficult to project. The budget for these categories is based more on historical information and the executive director's specific knowledge in these areas.

Sample Statement of Financial Position

Assets: (in IDR)	
Cash	40,000,000
Accounts receivables	4,000,000
Investments	16,000,000
Fixed assets, net	20,000,000
Total assets	80,000,000
Liabilities: (in IDR)	
Accounts payable	12,000,000
Accrued liabilities	6,000,000
Total liabilities	18,000,000
Net assets: (in IDR)	
Unrestricted	62,000,000
Temporarily restricted	0
Permanently restricted	0
Total net assets	62,000,000
Total liabilities and net assets	80,000,000

There should be a direct relationship between projected revenues and the expenses that will be incurred to carry out the CSO's mission. Preparing the revenue side of the equation first will make clear the extent of programs and services that can be rendered. Budgets should be prepared on a seasonal basis. If the organization is operating under the accrual method of accounting, reflect the revenues and expenses when earned and as incurred. If the cash method is used, show in each month the projected cash receipts and disbursements. Preparing the budget in this way will make the monthly financial statements more meaningful when results are compared with the budget.

Although the budget is often considered a working document, its purpose is to make estimates of future revenues and expenses and thus to serve as a management tool. There usually is no right or wrong budget. Because a budget will never be perfect, those who prepare it should do the best they can with the information available, be prepared to defend it, and then utilize it as one measure of the success of the CSO's programs and services. Understanding and responding to significant variances from the budget is probably one of the most important responsibilities within an organization.

Financial Statement Preparation

The accounting cycle is complete when financial statements are generated and then reviewed. Financial statements should include:

<u>Statement of financial position – balance sheet</u>

Reports the assets and liabilities of an organization at a particular point in time. It usually includes three sections:

Sample Template: Statement of Activities

	Current Month Actual	*Current Month Budget*	*Current Month Variance*	*Year-to-Date Actual*	*Year-to-Date Budget*	*Year-to-date Variance*	*Annual Budget*
Revenues							
Contributions							
Fees							
Fund-raising							
Investment income							
Other income							
Total unrestricted revenues							
Expenses							
Transportation (train, bus)							
Training facilities, materials							
General & administrative							
Fund-raising							
Total unrestricted expenses							
Increase in unrestricted net assets							
Net unrestricted assets at beginning of year							
Net unrestricted assets at end of period							

- Assets – Checking and savings; investments and reserve funds; the organization's fixed assets, including furniture and fixtures; and accounts receivables and other items of value to the organization.
- Liabilities – Amounts owed to vendors; deferred income (income to be recognized in a future period); and other obligations the organization has incurred.
- Net assets – Reports the cumulative net worth of the organization.

<u>Statement of activities – income statement</u>

See sample template above. The statement of activities measures (in fiscal terms only) the effectiveness of the organization's ability to carry out its mission. It reports revenues and expenses and shows the change in net assets from one year to the next. If the statement of activities is made public, it is recommended that the budget column be taken out, since it is internal information.

Review and Analysis

The leadership of the organization has a responsibility to review the monthly financial statements in order to identify errors, trends, and unusual transactions. Particular items should be considered:

- Examine the balance in prepaid expenses and prepaid income to ensure that increases or decreases in balances are appropriate, given the timing of the CSO's activities
- Examine the balances in fixed asset accounts and make sure that there are no significant increases or decreases without prior knowledge and approval
- Ensure that the accounts payable balance remains in line with expectations
- Examine major sources of income to determine whether actual results are in line with the budget. Request explanations for significant variances.
- Examine expenses that exceed the budget. Obtain explanations for significant variances.
- Examine expenses for programs and services and obtain explanations for significant variances.

Statement of cash flows

This statement reconciles cash flows from operating activities, investing activities, and financing activities. It is a required statement that accompanies the financial statements as part of the annual audit. Small non-profit organizations do not usually prepare this statement on a monthly basis.

4.4 Policies and Procedures

To ensure that the accounting cycle is completed as directed by management, your organization should develop and maintain a fiscal policies and procedures manual. The manual does not need to be lengthy, but it should be formalized and the staff should be instructed to follow it at all times. It should include the following topics:

- Financial statement presentation
- Distribution and timing of the financial statements
- Chart of accounts
- Bank account reconciliation procedures
- Check-signing procedures
- Travel expense policy
- Revenue collection and recording
- Payroll policies
- Insurance
- Controls over fixed assets
- Budgeting
- Tax filings

The fiscal policies and procedures manual can be an evolutionary document that expands as your CSO's operations become more complex. It will promote operational efficiency, which will permit you to concentrate on providing programs and services and carrying out your organization's mission.

4.5 Potential Funding Sources for Non-Profit Organizations

Resources are vital for the survival or any organization and financial resources are among the most important. Even if an organization has excellent, highly committed people to engage in the organization's activities, not much can be done without access to adequate, stable and reliable financial support.

If a CSO is a *Yayasan*, the Rp.10 million initial capital, which is the minimum amount required by law (Article 6, PP 63/2008) to establish a *Yayasan*, provided founders are all Indonesian. It is barely sufficient to pay for the very basic operations of a not-for-profit organization. Fund raising is therefore a very crucial function for any not-for-profit organization. Note that if the founders of the *Yayasan* include a foreigner the minimum initial capital is Rp. 100 million.

Following is a list of potential sources of financial support for a MARPs not-for-profit CSO:

- Local government budget allocation for specific CSO programs and services that serve the MARPs community
- Individual donors
- Business Corporate Social Responsibility (CSR) programs
- Foreign government embassies and/or aid agencies (or their projects)
- International NGOs
- Multi-lateral agencies, such as the Global Fund
- Endowment Funds
- CSO's own business income
- Public fund raising
- Sponsored charity events
- Members' routine contribution (only for *Paguyuban*)

4.6 Additional Resources

The Indonesian Accountant Association, or Ikatan Akuntan Indonesia (IAI), is the authority that issues rules regarding accounting practices in Indonesia through its special policy division. The policies in accounting practices are issued in what is called Statement of Financial Accounting Standards or Pernyataan Standar Akuntansi Keuangan (PSAK). Each PSAK is numbered and one issued specifically for non-profit financial reporting is PSAK No. 45. It is recommended that CSO become familiar with what is required in the statement.

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SECTION 2: TECHNICAL CAPACITY PERFORMANCE

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1. Gaining Access to Target Population

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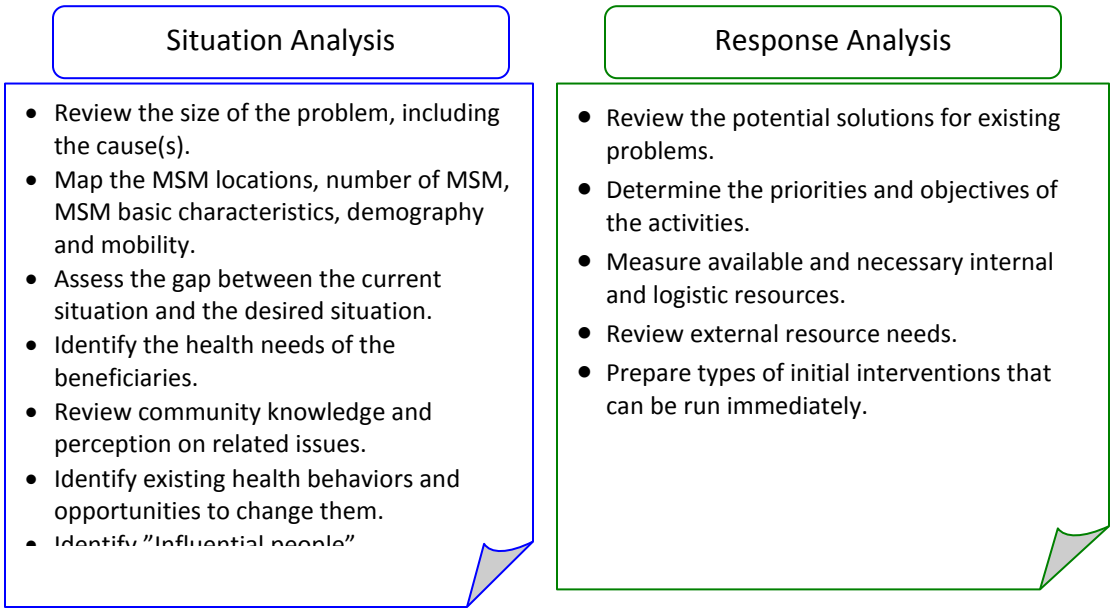
1.1 Rapid Needs Assessment (RNA)

Rapid Needs Assessment (RNA) is one of the tools used in program planning. It is a process to determine and respond to the needs, or gaps, between the current situation and the desired situation, leading to the attainment of the final program objectives.

In RNA, the needs explored can be various and should be predetermined before implementation so the information collected is appropriate for the situation. The speed of exploration varies, and in general requires several days (and rarely more than a month). The RNA can also be used to rapidly strengthen existing program responses (over several days to several months).

1. Scope

Generally, RNA is performed in the beginning of the program. In this context, the basic objective of the RNA is to review the situation (situation analysis) and to study the response needed (response analysis). The scope of RNA is illustrated below.



2. Objectives

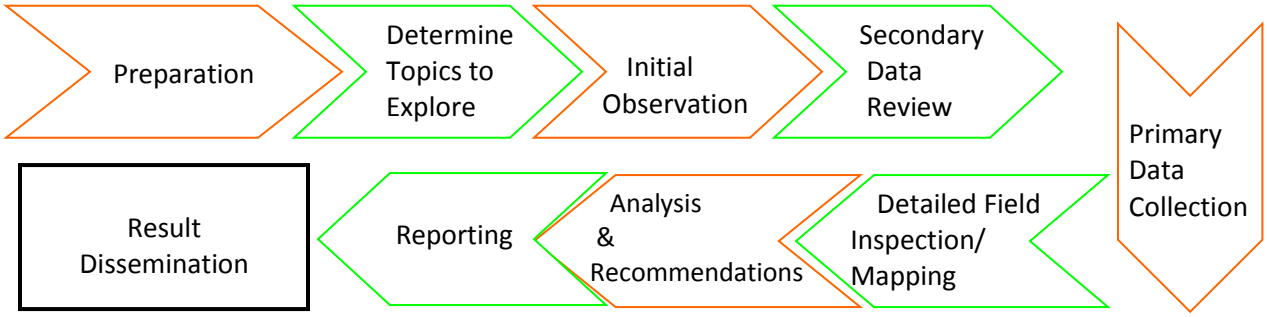
RNA objectives in the beginning of the program are to:

- Understand the situation of the program beneficiaries or key population
- Identify the existing response situation
- Identify further necessary responses

As stated above, RNA can also be done any time during the program for certain reasons, such as to learn more about a specific issue for strengthening the program. The objective of RNA in this context will be related to the issue to be explored.

3. Stages

The main stages of RNA include:



Stage 1 Preparation

Clarifies:

- Implementers
- Timeframe
- Implementation schedule
- Necessary materials, tools, equipment, and permits
- Initial list of resource people,
- List of institutions with information related to the RNA topic
- Preparation of necessary letters, forms, checklists

The preparation stage will be repeated if data collection is needed for a different set of issues.

Stage 2 Determine Topics to Explore

This stage gives direction to the kind of information needed. Even so, once in the field and in the process of exploration there should be flexibility, i.e., if the information needs to be expanded, reduced or deepened.

Stage 3 Initial Observation

This stage, completed in a short time period, helps the RNA implementer be selective in determining what needs to be observed, what design to used for primary data collection, and what secondary data is needed. The initial observation usually focuses on what is seen

physically and with little effort. A scan of the physical environment and beneficiary characteristics can usually be accomplished during this initial observation, although it will be done deeper and re-verified during the next RNA process (detailed field inspection/observation stage).

Seven central topics that should be probed using RNA in the beginning of the program include information on:

1. The physical environment situation (number of locations, spread, distance, type of location/building, location management, transportation access, etc.)
2. Beneficiary characteristics (number, demography, socio-economic status, location, spread, mobility, etc), social and sexual network, situation of the existing/potential social support of the beneficiaries.
3. Knowledge, attitude and practice related to STI, HIV and AIDS.
4. Health services and their access.
5. Prevention materials (such as condom and lubricant) and their access
6. What was done before and the results related to HIV prevention in that location.
7. Beneficiary and surrounding community aspirations on how the IPP program should be implemented.

Stage 4 Secondary Data Review

The secondary data review – documents, program data, books, journals and related study results – is conducted to get an idea on:

- What has been "said" by others on the location and beneficiaries during exploration?
- What has been learned about the knowledge, attitude and behavior of the beneficiaries related to STI and HIV/AIDS?

To the extent possible, the secondary data below should be collected and analyzed:

- Demographic and epidemiology data to identify the causes and factors that put people at risk of HIV. The data include data on HIV and AIDS cases, STI cases, as well as their incidence and prevalence, including estimation data.

- Behavior data to identify the mode of transmission among at-risk populations. These data include sexual network, condom use, age of sexually active, relationship between sexual behavior and alcohol, narcotics and other issues.

- Social-economic and culture data, including the situation and structure of the social support, literacy level, health data, migration pattern, mobility, social class division, gender role or values related to sexual activities and affection.

- Data on the broader social environment that may not be directly related to HIV/AIDS but will have impact on HIV prevention, support, care and treatment, overall health system or community expectation towards program participation.

Stage 5 Primary Data Collection

Primary data collection is conducted to collect more detailed and in-depth information on specific issues that cannot be collected through simple observation. Several techniques can be used for this primary data collecting including:

- **Interviews**: Structured, e.g., using questionnaires, and unstructured, e.g., using a general interview guide for more in-depth information gathering. Relevant parties interviewed should include: the beneficiaries, local stakeholders, RT/RW, village/*kelurahan,* sub district and city/district level government officers, as well as the beneficiary's clients, regular partners, etc.

- **Focus group discussion (FGD)**: Used to collect general and specific information, clarify details or collect opinions on an issue from a small group consisting of people that represent several points of view. FGD can also be used to build consensus.

Basic Steps – Focus Group Discussion (FGD)

1. Determine the FGD participants (5-10 are the ideal numbers). Depending on the objective of the FGD, the participants can be homogenous or heterogeneous. Several FGDs can also be conducted with different homogenous participants, so the results can be compared.
2. Formulate discussion guide using open questions.
3. Discuss the questions in the guide – one by one, with a facilitator as the leader. Make sure that all questions can be discussed during a period of 1-2 hours. Remind the facilitator his/her role is to make sure that everyone is talking, maintain focus on the topic, or repeat question – not to intervene in the discussion.
4. Make a recording or take detailed discussion notes. If the facilitator and note taker are good, the FGD can produce a list of rich responses and insights on the knowledge, language, attitude, feeling and behavior of the participants.

Stage 6 Detailed Field Inspection and Mapping

This stage is another part of primary data collection. This activity is conducted as a follow up from the initial observation, and the interviews and FGDs. The observation is an "active" observation, in that the observer also asks or digs out information from what he/she sees to make sure his/her initial assumption and assessment is correct, or to get people opinions at the location.

This detailed observation is performed in each location, one by one, so that the description produced will be more complete and accurate.

Stage 7 Analysis and Recommendations

This stage is conducted when all data needs and mapping have been sufficiently addressed. The analysis should include these core issues:

1) Gap analysis – The current situation compared to the real needs of the beneficiaries in order to prevent HIV transmission
2) Priority activities and important issues to consider during implementation of activities
3) Causes of transmission and beneficiary vulnerability for HIV transmission and opportunities to change them
4) Possible solutions to do immediately and over the long term
5) Compare consequences if an activity (or a series of activities) is implemented or not due to various limitations or barriers
6) Needs for capacity building for beneficiaries and the community, as well as other interventions for the target community and donor institution; and identifying what can be done by the institution alone and what should be done by working together with professional partners to get optimum results.

Recommendations from this stage should be focused on urgent matters for each location and population (if the intervention is done in several locations and populations) that 1) should be done, 2) need to be done, and 3) cannot be done or should be avoided.

These kinds of recommendations will help in mapping the "optimum role" and "program comparative benefits" – the location, population, and easiest, quickest interventions that will have significant impact on the HIV epidemic. A brief recommendation is summarized using the following table:

	Type of Intervention	**Location**	**Population/Beneficiary Type**	**Potential Partner(s)**
Should be done				
Need to be done				
Cannot/No need to be done				

Stage 8 Reporting

The report should be brief and concise to assure it is read by related parties. Attach appendices to the report that include all data and existing findings.

Stage 9 Result Dissemination

Result dissemination should include all relevant parties, including all team members who will be involved in the implementation of activities and help in the response to RNA results or findings, such as related government

In planning for dissemination of results, consider which findings or information might be too sensitive to share with certain audiences, such as information that might hurt community trust and future collaboration.

institutions and the community.

Because the RNA process always involves making summary, interpretation and reinterpretation of new data or existing data, it is important to give opportunities to the community to give feedback and further inputs, especially from all people who have given information during RNA. The result dissemination forum is one of the alternatives to do this.

It should be remembered that the result dissemination to the community does not mean presenting all findings. The implementer should select the information to be presented and the information that would be more suitable to present at another time and with other audiences.

4. RNA Targets

1) Institutions/individuals who have secondary data and who relate to programs in the key population
   - Social Affairs office
   - Health office
   - Family planning and population office
   - Civil Police Force (Satpol PP)
   - Police force
   - Health provider
   - Local NGO
   - Local study center/researcher
   - Local mass media

2) Information source in the community that can give primary data
   - Key population or beneficiary (e.g., MSM and MSW)
   - Informal groups organize themselves in certain cities (e.g. Gaya Delta near Surabaya is an informal MSM group)
   - Individuals who understand the key population or have regular contact with beneficiaries, such as the owner/manager of a massage parlor, entertainment center managers, boarding house owners, health care worker, *preman* (location bodyguard), researcher who understands beneficiaries, journalist who often writes on issues around beneficiaries, etc.

5. Resources, tools and materials

Some tools needed to do RNA include:
- Contact details for resource people, both individuals and institutions
- Secondary data
- Questionnaire/interview guide
- Focus group discussion guide

- Recorder or audio visual recorder
- Field inspection checklist
- Recommendation form
- RNA report format
- Map of the area
- Software that makes it possible to visualize the mapping results

6. RNA Monitoring

Monitoring for this activity is generally focused on each stage of the RNA implementation and the predetermined objectives of the RNA.

To monitor the implementation of each RNA stage, the person in charge for RNA can use a simple checklist that includes an activity list for each stage of RNA, implementation time and person in charge.

Implementation process monitoring in each activities in an RNA stage (especially to see the quality of implementation) can be conducted through direct observation, reading activity reports, and meetings with RNA implementing staff.

To monitor the attainment of RNA objectives, the person in charge for RNA can compare the predetermined objectives with the output produced. Make sure that all outputs have been written down in a document using a certain format that is as simple as possible and easy to read.

1.2 Socialization to the End Beneficiaries and Stakeholders

1. Scope

Socialization is the effort to promote the program to the stakeholders and MARPs to gain support in planning, implementation, and monitoring and evaluation of the program. Socialization can be done individually or in a group (small or big), and it can be formal and informal. The situation can also be varied depending on the field reality.

Socialization is a program-long process because the mobility of stakeholders and MARP occurs all year long. Informally it is necessary to continue socialization with individual stakeholders for maintaining strategic relationships on an ongoing basis.

2. Objectives

The objectives of socialization of the program are to:

- Assure that the stakeholders and MARPs recognize the existence of the program and the program objectives.
- Assure that stakeholders and MARPs support the program to be performed in their area.
- Identify the forms of support and potential barriers that may be faced by the program in the future.

3. Targets

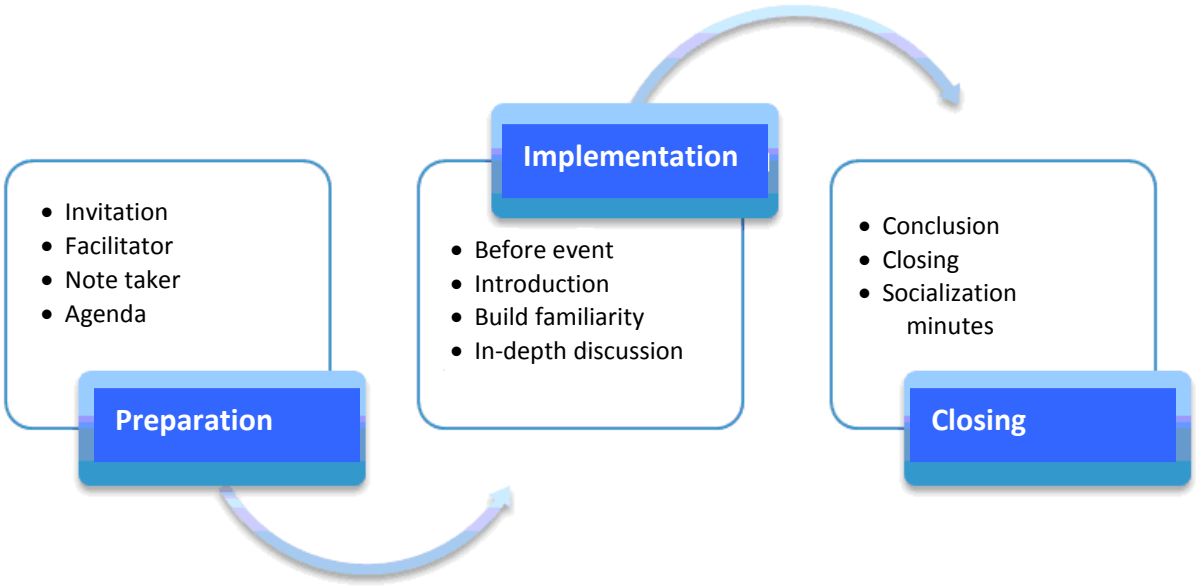
The targets of the socialization are:

- Area stakeholders (government officers from related local government institutions)
- Local stakeholders (key person at the field/hotspot level), and
- Program beneficiaries

The targets of socialization can be broadened according to the need and situation of the field. For example, it can include potential partner institution, influential individual leader, etc.

4. Stages

The stages of the socialization can be various depending on the situation. However, the socialization in general follows the following stages:



Preparation Stage

Invitation. The program implementer needs to decide how the invitation will be given to the socialization candidates, especially for location-specific stakeholders. It does not have to be on paper. In several settings, personal invitation by direct visit is more effective.

If your institution has already conducted a program over a long period of time and is known by the stakeholders, you can invite them independently. However, when there are certain difficulties, you can ask for help for other institutions (government/ non government) to invite the participants on behalf of your institution.

Facilitator. During the first socialization or follow-up socializations, the role of facilitator is always important. He/she has the role to make sure that all agendas are performed using certain arrangements and flow. In addition to the facilitator, you might invite a resource person for a certain topic. Both resource person and facilitator can be people in the institution or someone from outside that you have briefed to guide the socialization process. The facilitator and resource person should be someone who is considered credible by the socialization participant. Sometimes, the facilitator and resource person roles are conducted by one person only.

The specific role of the facilitator during socialization process is to:

- Introduce the discussion topic
- Guide the group
- Observe participants and respond to their reactions

- Make sure that the agenda is run according to plan
- Develop tools to make the meeting process easier
- Help the group draw conclusions and identify action steps (i.e., an action plan).

Requirements for a facilitator include being relaxed, helping participants relax, showing warmth and empathy, using good communication and listening skills, showing enthusiasm for the topic, ability to read the audience (i.e., aware of non-verbal signals from the participants), and ability to think analytically.

Note taker. Document all processes during the socialization event, and the conclusions and agreements reached. You may assign a staff member who is capable of this task.

The role of the note taker is:

- Taking notes on the date, venue, time, participants, group dynamics, core opinions stated, local terms, conclusion reached, follow up plan if any, participant questions and answers.

- Note taker participation: A note taker can ask the participants to repeat comments or ask additional questions if it is necessary to clarify discussion.

Agenda. The agenda is tied to the socialization objectives. The program implementer should design the flow of the agenda so it is reasonable and as simple as possible in guiding the discussion towards achieving the objectives. The agenda should consider the venue, time available, tools, number of participants, and complexity of the tools. In general, the socialization agenda includes:

- Opening
- Introduction
- Description on the meeting objectives
- Discussion process
- Conclusions and agreements
- Summary and closure

Implementation Stage

Before implementation. The following should be done before the meeting is conducted:

- The facilitator and note taker should arrive before the participants
- Interact informally with participants as they arrive
- Arrange the seating
- Prepare necessary tools and equipment

Introduction. During the introduction:

- Introduce the facilitator, note taker, resource person, organizing members, implementing organization and participants.
- Explain in general terms the rationale for the event
- The program implementer/facilitator states that he/she would like to learn from the audience and that the opinions of the participants are important
- The facilitator will not assess the participants' answer. All answers are important to be considered.

Building a sense of familiarity. Begin building a sense of familiarity from the start of the meeting and continue until socialization process is finished. This can be done through a creative introduction process, participatory objective formulation process and by keeping the discussion focused and direction clear.

In-depth discussion. In-depth discussion is a core process of the socialization event. At this stage, the meeting objectives are discussed in depth, summarized, concluded or agreed. The in-depth stage needs certain process design. The process design needs to be adapted to the objectives to be attained.

The program implementer should apply well-known techniques during the in-depth discussion. For example, in identifying problems the program implementer can use problem tree analysis or other similar techniques. A problem tree analysis is similar to a mind map and is used to find solutions by mapping out the cause and effect of issues.

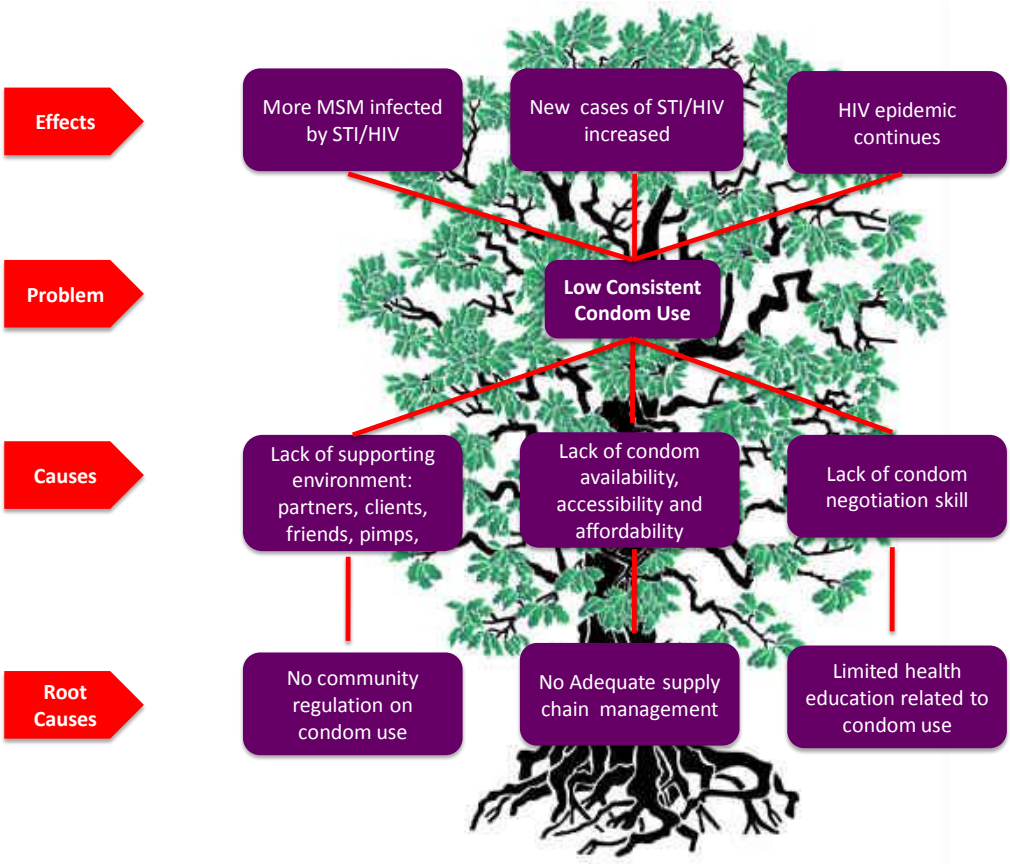
Problem Tree Analysis

Problem tree analysis is best carried out in a small focus group of about six to eight people using flip chart paper or an overhead transparency. The first step is to discuss and agree on the problem or issue to be analyzed. The problem or issue is written in the center of the flip chart and becomes the 'trunk' of the tree. This becomes the 'focal problem'. The wording does not need to be exact as the roots and branches will further define it, but it should describe an actual issue that everyone feels passionately about.

Next, the group identifies the causes of the focal problem – these become the roots – and then identify the consequences, which become the branches. These causes and consequences can be written on post-it notes or cards, perhaps individually or in pairs, so that they can be arranged in a cause-and-effect logic. The heart of the exercise is the discussion, debate and dialogue that are generated as factors are arranged and re-arranged, often forming sub-dividing roots and branches (like a Mind map). Take time to allow people to explain their feelings and reasoning, and record related ideas and points that come up on separate flip chart paper under titles such as solutions, concerns and decisions.

Discussion questions might include:

- Does this represent the reality? Are the economic, political and socio-cultural dimensions to the problem considered?
- Which causes and consequences are getting better, which are getting worse and which are staying the same?
- What are the most serious consequences? Which are of most concern? What criteria are important to us in thinking about a way forward?
- Which causes are easiest / most difficult to address? What possible solutions or options might there be? Where could a policy change help address a cause or consequence, or create a solution?
- What decisions have we made, and what actions have we agreed?


Effects
Problem
Causes
Root Causes
More MSM infected by STI/HIV
New cases of STI/HIV increased
HIV epidemic continues
Low Consistent Condom Use
Lack of supporting environment: partners, clients, friends, pimps,
Lack of condom availability, accessibility and affordability
Lack of condom negotiation skill
No community regulation on condom use
No Adequate supply chain management
Limited health education related to condom use

Closing Stage

The conclusion or mutual agreement. Getting clear conclusions is not always easy. If difficult, the program implementer can provide a summary of the meeting as opposed to drawing conclusions. The agreement can include agreements on issues, process, follow-up actions, and hoped-for results.

Closure. Bring the meeting to closure when there are no more opinions coming or the time is up. Thank the participants for their presence and participation during the meeting. Give appreciation and describe next plan that will be conducted after the socialization meeting.

Socialization meeting minutes. After the socialization is finished, the facilitator, note taker and other socialization organizers should meet to discuss important results of the meeting. Written notes should be made. If it is necessary, the socialization minutes can be distributed to the participants. Include the following in the minutes:

- The objective of the meeting
- Important results achieved
- Existing follow up plan
- Participants

5. Resources, tools and materials

The following tools and inputs should be provided for the socialization meeting:

- Invitation to the meeting, or delegate someone to make telephone calls, etc., if a written invitation is not being sent
- Meeting venue
- Meeting aids as necessary, such as metaplan, flipchart, worksheet, LCD, laptop
- Materials for the meeting
- Stationary
- Snack and/or lunch

6. Monitoring

The indicators for the socialization meeting are as follows:

<u>Quantitative</u>

- Number of participants presence
- Number of socialization meetings
- Number of representatives of each participant group
- A follow up plan produced

Qualitative

- Level of participation of the meeting participants
- Agreements or follow up plan
- Issues debated without any agreement reached

Successful socialization meetings in the beginning of the program should help the acceptance of the program by the target community.

1.3 MARPs Involvement and Recruitment to Penetrate the Networks

MARPs can be involved in the program as a target, an implementer, and an evaluator of the program. The involvement should be significant in terms of number, representativeness, process and the depth of involvement. The involvement is important for the sustainability of the program. The more the MARP are involved, the better the program and the more independent the community.

1. Scope

The involvement process can be done in stages depending on community preparedness. Along with the capacity building process, the involvement level usually increases. One of the most important things is MARP as part of the program implementing staff. For this reason, the recruitment process for MARP as a program implementer should be developed.

The program and the community will gain benefits from this process. However, this benefit will be greater if the recruitment process involves systematic and sustainable methods. The benefits include:

1) The program becomes more culturally sensitive and adapts to the culture of the MARP
2) Facilitates a closer and more harmonious relationship between the program and the MARP
3) Strengthens program legitimacy among MARP
4) Easier to change technical information from the community into language/ concepts that are understandable to the program implementer
5) Increases MARP attention towards the threat of HIV and AIDS
6) Improves understanding of norms, values and perspectives, which results in more suitable risk reduction strategies
7) Provides access to circulating rumors and unofficial information to help monitor the adoption and maintenance of the risk reduction plan
8) Increases opportunities to reinforce behavior change because of their perspective and their relationship with other social network members.

These methods should involve selection, recruitment, capacity building and continual support of MARP members.

2. Objectives

The objectives of MARP involvement through the recruitment of MARP member as program staff are to:

- Recruit staff members from the MARP
- Increase MARP acceptance of the program

- Improve program effectiveness by increasing the participation of MARP sub-groups

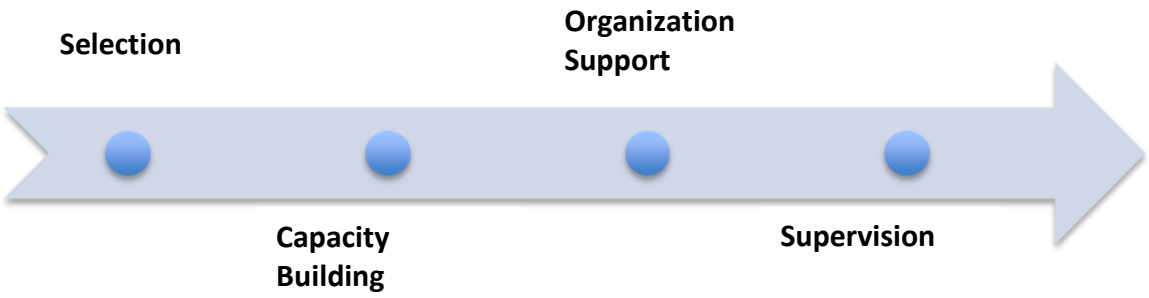
3. Target

The targets of this activity are:

- Institutions that plan to use an indigenous outreach worker approach
- MARP members considered to have potential

4. Stages

The MARP recruitment stages for program implementation include:



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2. Increase Knowledge and Awareness

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2.1 Outreach

1. Scope

Outreach is defined as direct contact, both individually and in a small group (2-10 people), with people who engage in risk behaviors. Outreach takes place at the locations where these people usually hang out. Outreach workers give information, distribute prevention materials and IEC media, promote safer behaviors and refer them to the necessary related services.

Outreach is used to gain access to populations that are difficult to reach because they are hidden populations (geographically, socially and culturally), such as FSW, IDU, MSM and *waria*, and high risk adolescent groups. After assuring that a good relationship based on trust is built with the community, the outreach worker (OW) becomes the agent to change behavior and offer him/herself as the information source for HIV and AIDS education.

The main reasons why these groups should be targets of outreach:

- The characteristics of the group are specific
- There are gap and barriers to access information and education
- There are gap and barriers to access health services and related services
- It is one of the methods with high intensity that enables the contact to change behavior

2. Objectives

Specific objectives of outreach are:

- To increase HIV and AIDS related knowledge
- To increase awareness about the individual's risk caused by the behaviors
- To change beneficiary risk behaviors into safer behaviors in term of STI, and HIV transmission.

To reach the above objectives, the information package should include:

- STI, HIV, AIDS, and HCT information
- Information on prevention materials (condom and lubricant) and IEC media
- Information and education on condom negotiation skills, including other safe sex alternatives
- Information on how to access services related to STI, HIV and AIDS, and STI, HCT, CST services (CD4 test, OI treatment, CM service, PSG, spiritual services, etc.).

Other information can be provided upon request, including:

- Information on reproductive health and sexual health

- Information on drugs and addictive substances
- Gender and sexuality
- Legal issues and human rights
- Others

Outreach

One *waria*-led CSO works in the streets, laneways, parks, and homes of *waria* across Jakarta. Its outreach services divide staff and volunteers into teams each responsible for a district of Jakarta and these teams distribute condoms and lubricant, talking to *waria* and helping them resolve the difficulties they experience in their daily lives. "I have three 387 *waria* in West Jakarta that are my responsibility," says one field worker, who emphasizes that *waria* talk, "not just about HIV" but also about money, problems with the police, housing, sex and love.
Their partnership with *Forum Komunikasi Waria* means that they combine HIV outreach with advocacy and legal representation for *waria* and allows the *Forum* to quickly learn of the difficulties that *waria* are experiencing and advocate on their behalf. The field worker says "I feel happy because many of waria clients... maybe 80 percent now have awareness to live healthy." She uses the word "empowerment" to describe these 80 percent who now, she says, have the capacity independently take care of their own health.

One important role that *this CSO's* field workers play is to bridge the gap between *waria* networks and health services. "A key goal of our outreach is to encourage *waria* to attend health services," explains a field worker. "Many *waria* are afraid to attend these services. They are afraid of needles and they feel the hospital is so different and so strange." The entire *CSO* team emphasizes that poverty and lack of education remain the major barriers that prevent *waria* attending services. Their experience is that *waria* "will not go to health services because they cannot afford to pay." The reality is that most *waria* in Jakarta live in extreme poverty and their poverty is directly caused by their inability to participate fully in Indonesian community life. While some *waria* have begun to appear "in beauty salons or are working as designers..." and "there is a transgender that has become a government employee also," a source of sadness for the CSO team is that "we *waria* are sex workers, beggars or singers on the street" and there are often few other options available. *Waria* are subjected to violence and harassment by public order officials and police and are often detained in government facilities. This in turn leads to extreme distrust of official services. Because of this extreme distrust, the CSO must first accompany *waria* to health services while (due to extreme poverty) they must often pay for the health care services their clients receive.

3. Principles

Outreach does not only mean approaching someone, giving information and then meet the person again in the future. During the process, there are certain principles that should be applied to give quality outreach and to attain expected behavior change. The principles of outreach are:

- ***Empowerment principle***

Beneficiaries of outreach are the people who will make the behavior change and therefore are actors in the behavior change process. Outreach education gives them the capacity to do behavior change, e.g., how to have safe sex, how to access appropriate treatment, etc. The outreach worker plays the role of facilitator to help the beneficiaries take these actions – to increase an individual's ability and skills (understanding, decision-making, choice-making, new behavior trial and maintenance).

- ***Relax and informal principle***

Outreach takes place in a flexible atmosphere – open, no pressure and informal. The meeting does not disturb the beneficiary's daily activities. For that, the OW should have the skill to read the situation and act flexibly, which is very important to apply in various situations. Therefore, it is important for the OW to adapt field plans that he/she has made to the situation faced or that will be faced at an outreach location.

- ***Triangulation principle***

Triangulation is a form of data re-checking. Data that are collected (from OW reports) are usually classified, analyzed and used as input to program policy making, as per the current situation faced by the beneficiaries. For this reason, this information needs to be triangulated. During the outreach process, we often get different perspectives on an issue. To find out if information is accurate on an issue, the OW needs to triangulate the interaction with the beneficiaries.

Triangulation can be performed using three basic strategies:

1) Source triangulation: cross check the information with other sources/beneficiaries, compare and perform data contrasting, use different informant/beneficiary category.

2) Method triangulation: using several methods in data collection/verification (such as individual face-to-face contact, group meetings or observations, and in-depth interview.

3) Data or analysis triangulation: conducting analysis by more than one person, and asking feedback from the informant/beneficiaries.

All these efforts are used to give appropriate support for the needs of beneficiaries and to solve problems among beneficiaries. It is important that the outreach documents are used for OW follow-up planning, especially in fulfilling the needs for behavior change, IRA activity planning, and networking for health service access. Good decisions for future OW plans will result through triangulation

- **Information intensity and depth principle**

Behavior change can take a long time, and continual and focused attention – frequent meetings with updated information based on needs, knowledge, and attitudes of the beneficiaries – is required. It takes at least several contacts to help a person changes his behaviors. For this reason, outreach and contact activities require treatments specific to the beneficiary or beneficiary group.

- **Trust and confidentiality**

These two attitudes are very important and are earned from beneficiaries. The OW should position the beneficiaries as important people to be served. This is important because of the issues we are dealing with (sexual problems, diseases, behaviors) are sensitive and private matters for the beneficiaries. To encourage people to disclose their behaviors and be willing to plan for behavior change, trust and confidentiality in the OW-beneficiary relationship is required for successful outreach.

- **Creativity**

This principle of creativity underlies the OW's sensitivity to problems and events observed, and how they get addressed in follow up actions. It requires that each OW to look for ideas and new types of activities which are sustainable. For example, the type and amount of information that the beneficiary prefers to receive varies widely, so the OW needs to adapt to these preferences and use creative follow-up approaches.

Other methods outside the existing and familiar methods may be required to stimulate behavior change. This discovery process should consider the beneficiary's acceptance, his characteristics, local culture and other factors such as mobility, daily routines, and social relationships among beneficiaries at the location.

- **Assessment principle**

The assessment principle means that the outreach worker understands all aspects related to the beneficiary (characteristics, knowledge, attitude and behaviors, environment, etc.), which

enables him to more easily adapt information and outreach methods, and develop the type of support appropriate to the environment that is needed to motivate a beneficiary's behavior change.

An outreach worker should be able to assess the beneficiary and the beneficiary's environment through observation and interviews at the location so planning (i.e., mapping, scheduling) can be done appropriately, based on the beneficiary's needs, and accepted by the beneficiary.

4. Stages

Stage 1	Planning
a.	**Mapping** Do physical and social mapping based on domicile/house for all intervention locations where the intervention will be done. Use the mapping guidelines.
b.	**Outreach scheduling** Determine: 1. When outreach needs to be done in each location: what day, at what hour. 2. How many times outreach needs to be done in a location in a week or a month. 3. The time that should be allocated for each outreach activity in a location 4. The number of outreach workers (OWs) that will be sent for each outreach activity or in a location. 5. If there will be a rolling/substitution among OWs in a location or a beneficiary type with the OW in other locations or for other beneficiary types. If yes, when and how long this rolling will be done.
c.	**Field Coordinator and Outreach Worker Assignment** 1. Consider several things below when assigning field coordinator and outreach worker: → adjust to experience, OW specialization and number of OWs → adjust to location type and beneficiary type → sometimes it is necessary to adjust the gender or sex orientation of the Field Coordinator/OWs with the beneficiaries 2. Consider several models of assignation that are considered the most appropriate for the existing situation:

	a. Model based on the location/hotspot OWs are divided and distributed based on the type of location, e.g. OWs for brothel complex, OWs for massage parlor, OWs for entertainment center (discotheque, pub, bar, etc.), OWs for open site/street, OWs for working place/company, OWs for mall and beauty parlor, etc. b. Model based on the distance and size of the hotspot OWs are divided and distributed by considering the distance and size of the hotspot, e.g. OWs for area A that covers several *kelurahan/*urban villages (no matter the type of the beneficiaries in that area). It may include FSW, IDU, MSM or *waria*), OWs for area B in district X, etc. c. Model based on the type of the beneficiaries OWs are assigned according to the type of the beneficiaries, e.g. OWs for direct FSW, OWs for street FSW, OWs for indirect FSW, OWs for truck driver, OWs for motorcycle taxi driver, OWs for employee, OWs for transgender (*waria*), OWs for MSM, etc. d. Model base on OW's experience and specialization OWs are divided and distributed based on the previous OW experience and the preferred specialization. This model is similar to the models based on the type of location or the type of the beneficiaries. However, the main consideration in deciding the assignment of the OW is more on the OW's point of view and not from the field or beneficiary's point of view. e. Combination model OWs can be assigned according to the above models (a-d) such as model that combines the location type and beneficiary type (OWs for MSW in massage parlor) or the combination between the size of the hotspot and the type of beneficiaries (OW for MSM in mall).
Stage 2	**Implementation**
a.	**Opening access and gaining trust from the beneficiaries and community in the intervention site.** Consider and conduct one or more of the methods below: 1. Meet with key leaders: visits and personal meetings with beneficiaries and community leaders 2. Conduct formal program socialization with the beneficiaries and surrounding community 3. Send formal notification letter from the institution to the beneficiaries and community 4. Perform field observation/live in the outreach location 5. Perform an event to mark the start of the program 6. Get formal letters (containing approval/support/mandate/assignment/ recommendation) from related officers/institutions to be able to start a program in an intervention location 7. Establish a drop-in-center at the outreach location to get the program service closer to the beneficiaries and target community

	8. Distribute institution profile and program activity handouts to the beneficiaries and the surrounding community 9. Get involved in and support beneficiary and surrounding community social activities 10. Invite related technical institution to work together on program socialization 11. Give appropriate rewards to beneficiaries or community leaders who are actively involved and cooperative in showing attention and increasing motivation to the program.
b.	**Prevention material (condom and lubricant) and IEC material distribution** 1. Apply several main principles for distributing prevention material and IEC media on the field to reach optimal result: • Distribution of prevention materials and IEC media is a part of beneficiary education process. • Distribution is conducted selectively for efficiency reason, i.e. only for those who are interested or need it. • Distribute the materials along with explanation/discussion. • Distribution is adapted, in terms of the content and form of prevention materials and IEC media, according to distribution channels. For example, it is not appropriate to distribute booklet in a big campaign event. It is better to distribute leaflet or a similar type of media for this kind of event. • As much as possible, involve beneficiaries or community as the distribution channel, e.g. involving PE, coordinator/manager (pimps for MSW), etc. 2. Determine the number and type of prevention materials and IEC media to be distributed according to the beneficiary's need. Determine what percent the program can meet this need and involve other sources if there is a gap. 3. Make sure that the stock and storage system are adequate so that prevention and IEC materials are not damaged before being distributed. 4. Determine appropriate distribution channels so that the prevention and IEC materials can be distributed directly, rapidly and evenly among beneficiaries. 5. Define specific targets for the distribution of these prevention materials and IEC media. Certain prevention materials and IEC media are only appropriate for certain targets using certain channels. Avoid doing it uniformly for every situation because it will reduce effectiveness. 6. Involve beneficiaries and community in the distribution of prevention materials and IEC media. The involvement can be done at certain levels according to the ability and willingness of the beneficiaries and community. 7. Make a simple inventory system to monitor the existing distribution process starting from material reception, managing damage, storage, number distributed, including determining re-stock process.

	8. Monitor, record, and follow up complaints and feedback from the beneficiaries for the existing distribution system in order to continually improve the system. 9. Perform other long-term activities to meet the needs for prevention materials and IEC media, such as through condom social marketing program. 10. Gradually, give the responsibility for distributing prevention materials and IEC media to the program target community.
c.	**Share information/program messages and program issues (knowledge on STI, HIV and AIDS)** 1. Decide on the scope of information/messages to be shared. For HIV and AIDS, the information shared includes at least, but not limited to: <u>Mandatory information package for beneficiaries</u> • Information on STI, HIV, AIDS, and VICT • Information on prevention materials (condom and lubricant) and IEC media • Information and education on condom negotiation skill, including other safe sex alternatives • Information on how to access services related to STI, HIV and AIDS [STI service, VCT service, CST service (CD4 test, OI treatment, CM service, PSG, spiritual service, etc.)] <u>Other information that should be given if the beneficiaries ask about it or experience problems related to it:</u> • Information on sexual health • Information on drugs and addictive substance • Others 2. Formulate messages together with the beneficiaries that address beneficiary's need. The message should create awareness. Topics on HIV and AIDS need to be formulated in line with the field context so it is has a clear link with the real life of beneficiaries. The more contextual and personal a message, the more it will raise awareness and the likely that the beneficiary will adopt it and it will trigger behavior change. 3. Decide on the most appropriate media to communicate messages. It can be sent through many forms such as oral media, printed media, audio media, audio-visual media, etc. The most successful programs combine media to convey the message in outreach. Ask the beneficiary/target group who will receive the message for feedback. 4. Determine the most appropriate channel for messages and media - interpersonal, group or mass media. These channels have their own strengths and weaknesses and their use depends on the existing needs and objectives for beneficiaries. Ask for the beneficiary/target group for direct feedback. 5. Observe and adjust messages according to the beneficiary's level of knowledge, attitude or behavior.
d.	**Promote safer behaviors**

	1. Identify and group the most dominant unsafe behaviors of the beneficiary related to STI and HIV/AIDS transmission. 2. Specifically, narrow the scope of safer behaviors that should be promoted by the OW to the beneficiary includes the following behaviors: • Not using condom to → consistent condom use • Not routinely check his/her health to the health services to → routine examination at the health services • Do not know HIV status to → know HIV status through VCT • Self-treatment to → treatment by health provider at legal health services • Many partners or high frequency of changing partners to → reduce number and/or frequency of changing partners. 3. Create and promote "bridging behaviors" to make it easier for the beneficiaries to try and to do them and to increase beneficiary's confidence that he/she is able to do the behavior (self efficacy). For example, to reach the behavior change from "not using condom" to "use condom consistently", the bridging behaviors that need to be offered to the beneficiaries according to his/her situation are: • From not having condom to always have condom available • From asking for free condoms to buying condoms at the outlet/pharmacy • From not offering condom to having a courage to always offer condom to clients • From never using condom to trying to use condom although inconsistently • From sometimes use condom to consistent condom use with regular clients • Etc. 4. Involve and use experts (doctors, paramedics, community/religious leaders, celebrities, etc) to communicate and promote safer behaviors. Many people attribute more authority to who spoke than what was said. 5. Look for and use peers as a role models of behavior change. 6. Use rewards (in the form of word, action, materials), use beneficiaries as examples, and involve beneficiaries who have successfully used safe behaviors in activities. 7. Use personal approach to intensify safer behavior promotion and use group or mass approaches to increase coverage of safer behavior promotion. 8. Assign peer educators, peer support groups or other behavior change mentor to facilitate maintaining certain safe behaviors that have been newly adopted by the beneficiaries. 9. In the long term, encourage the community to commit to the program and support inclusive local regulations that promote, support, apply sanctions and expand safer behavior promotion for preventing STIs and HIV infection.
e.	**Refer beneficiaries to related services** 1. Determine the scope of referral aimed in outreach activities or general behavior change intervention. In the context of behavior change intervention for HIV prevention, an activity is called "beneficiary referral" if it involve the 3 following activities:

	a) Information on the risk of disease that might be experienced by the beneficiary/symptoms that the beneficiary complains of b) Information on how to access related service c) Motivation on the importance of being examined early by the health provider d) Referral card is provided to the beneficiary. The above conditions can vary for each area, but it can still be called referral if: • Information on the risks for the disease that may be experienced by the beneficiary/symptoms complained, information on how to access related services, and motivation on the importance of early examination and referral card are provided. • Referral may not be given if the beneficiary is directly accompanied by the Field Coordinator/OW to the service provider facility. • If the referral card is not given and the beneficiary is not directly taken to the clinic but there is already an established referral system, it can still be counted as referral. • Lastly, if the two conditions above are not met and when the service provider asks the beneficiary how he/she knows about the service, the beneficiary responds that they visited the service because of encouragement from the OW/PE, and then it is still considered as referral. If the four conditions are not met, the activity is considered promotion of service or distribution of information on how to access services, not referral. 2. Identify and establish collaboration with the nearest health services that become referral centers for beneficiaries in the *kelurahan/*village (if any), sub district, district to provincial levels. 3. Prioritize the beneficiaries for referral based on the situation, the urgency of the condition and long-term impact. Determine those needing accompaniment/directly taken by OW to the health service. 4. Conduct group referral to make the process of health service utilization by beneficiaries easier, e.g., by manager of the MSW or pimps, etc. 5. Record beneficiary feedback and complaints related to the referral mechanism and service process at the health service center. Communicate and decide on follow up if necessary. 6. In the long term, establish community agreement on referral system, examination and screening so that this activity can continue when the program ends. Link the community with existing and nearest health care centers so that they can work directly with providers.
f.	**Outreach reporting** 1. For each outreach or other types of contact with beneficiaries, the OW must make report. In the program context, this reporting functions as: • Proof of responsibility and that the outreach activity was performed • Indicator to understand the success of an activity

	• Help in developing follow-up plans • Program policy making materials • Program publication materials 2. Use simple form to record the outreach activities (refer to the FC/OW daily activity report form attached in this document). 3. Decide on outreach and other OW field activity reporting line. Usually the line is as stated below but it can be adjusted to the situation: • Report making by the OW • Report submission to the FC for correction and validation • Report submission to the data manager by the FC to be inputted into the program database • Program database recapitulation for monthly report
g.	**Follow up plan making** 1. After outreach and after the reporting is finished, the OWs, both individually and in a team, is supported by the FC to make follow up plan for each beneficiary (individual, group or certain location). The follow up plan can be very simple or complicated involving other institutions and even needing new policy from the institutions. 2. Determine the forms of follow up plans to be done, for example: • Re-contact on the next day or week • Bring HCT in the next meeting • Arrange education in the next meeting • Distribute more condoms in the next meeting • Deepen the outreach by IRA or GRA in the next meeting, etc. Expand follow up plans. To do so it is necessary to: • Approach the pimp so that he/she will allow the beneficiaries to go to the clinic for examination. • Negotiate with the clinic to be able to do mobile clinic activity to location X. • Choose one of the PEs in location Y as condom outlet manager. • Establish a drop-in-center in this location because the number of beneficiaries is high and the distance is far from the institution's office, etc. 3. Determine, if any, internal follow up plan for the program/institution is needed, such as re-scheduling of outreach activities, to add or reduce existing outreach frequency due to certain considerations. 4. *Case conference* among OWs and FC is usually held at least once a month for certain outreach cases/situations. However if there is an emergency or crisis situation, the case conference can be held sooner. Decide on follow up plans and uniform mutual responses for those cases.
Stage 3	**Monitoring**
a.	Focus on monitoring for the elements below: • Assess whether the activities performed have been conducted according to plan

	(in terms of methods, time, frequency, content, number of participants, results, etc.). • Involve continual processes in collecting and merging information/data from various places and time. • Use both quantitative and qualitative data • Give information and questions to program implementers and stakeholders if and where the existing efforts/activities should be modified to meet the needs.
b.	Determine the main aspects of outreach that are going to be monitored based on the existing needs. Always consider the following aspects: 1) implementation and target achievement of the activities and 2) performance and quality of outreach implementers.
c.	Develop and decide on the methods of monitoring to be done. Consider to always use one or several methods below: • *Desk review* This is performed by looking at and analyzing various activity reports collected through reporting and recording forms. • *Exit interview* This is performed by doing questionnaire interview, usually to determine the satisfaction of the activity beneficiaries such as interviews with some beneficiaries, certain training participants, or beneficiaries who have just been contacted by an outreach worker. Qualitatively, monitoring can be done through: • *OW routine meeting* This is usually done once a week. The person who monitors can be directly involved in this weekly meeting to select the meeting topic and discussion dynamics. • *Field Visit* This is conducted through direct observation on the field situation and observing how an activity is performed or how the OW performs his/her duty on the field. • *Key informant interview (KII)* This is performed randomly by interviewing several beneficiaries to determine the success of the activity according to the beneficiaries. Main questions are asked and can be expanded during the interview process. This method is similar to the in-depth interview. • *Focus group discussion (FGD)* This group discussion is held with several beneficiaries (usually 5-10 beneficiaries) from various places and social background. The monitoring officer usually prepares a question guide to get information from the beneficiaries. Topics to be discussed are predetermined and specific in nature (1 or 2 topics). FGD requires good facilitation skills (asking questions, analysis, probing, concluding, settle arguments, manage discussion flow, probing information from “silent participants”) and making an accurate result summary. • *Interview with the stakeholders*

	Interviews with stakeholders or field key people who are not beneficiaries are conducted. The stakeholders may include anyone such as pimp, social rehabilitation manager, massage parlor or entertainment center owner/manager or government institutions related to the program. • *Mystery clients/mystery guest* This is done by choosing a non program volunteer (someone from outside the program who is not known by the beneficiaries) to do direct observation in the field and conduct free interviews on certain topics with the beneficiaries.
d.	Set the period and time for monitoring so that it is fair and transparent and allow all persons to follow the schedule.
e.	Decide on the monitoring implementer; will it be the direct supervisor of the OWs, i.e. FC, or an outside person from an institution, or other?
f.	Monitoring should be based more on program data and not only based on individual observation.

5. Resources, tools and materials

Several tools and materials are needed to support the outreach activities:

- Mapping report
- Outreach documentation form
- Various forms of IEC media
- Condom and lubricant
- Dildo

Key Resources

USAID SUM Program CD-ROM

- *Outreach Standard Operating Procedure (SOP)*

2.2 Targeted Educational Sessions

1. Scope

Education sessions are activities designed to present information or teach certain topics to participants. Most education sessions use one-way communication methods, which do not involve much audience participation. In contrast two-way communication methods are more active and effective learning methods for conveying knowledge to an audience. If a speaker is talented, he or she can make the education session interesting.

Several skills can enhance the education session:

- Verbal skills
  - Clarity in speaking (and clear messages)
  - Asking and answering questions
- Non-verbal skills
  - Writing in front of the class
  - Eye contact
  - Class management: managing and orchestrating the activities
  - Voice intonation and volume
  - Mimics
  - Body language
- Method selection and usage
  - Using participatory method
  - Mix of methods, not just lectures

Strengths of education:

- Factual materials are presented directly and logically
- Can contain inspiring examples and experiences
- Can stimulate thinking in an open discussion
- Can be useful for a big group

Weaknesses of education:

- Facilitators are not always good communicators
- Audience tends to be passive
- The results of learning are difficult to measure
- Communication tends to be one way, so difficult to gauge audience interest and learning

- Tool and material selection and usage
  - Choose materials and tools that are less labor intensive to prepare for the facilitator
  - Master the way to use the selected tools and materials effectively
- Time management
  - Arrange the time so that the available time can be used in a very effective and efficient manner

- Audience management
  - Recognize audience characteristics
  - Build a positive relationship with the audience
  - Treat all people in the audience as equals

- Room management
  - Arrange the room in such way that will enable movement for the facilitator and participants as a whole group as well as in break-out sessions
  - Use interesting visual aids and other teaching aids to decorate the room. The learning environment can increase audience enthusiasm and interest.

- Mastering the materials
  - The facilitator should be thoroughly prepared, know the content and how to use materials before the session begins.

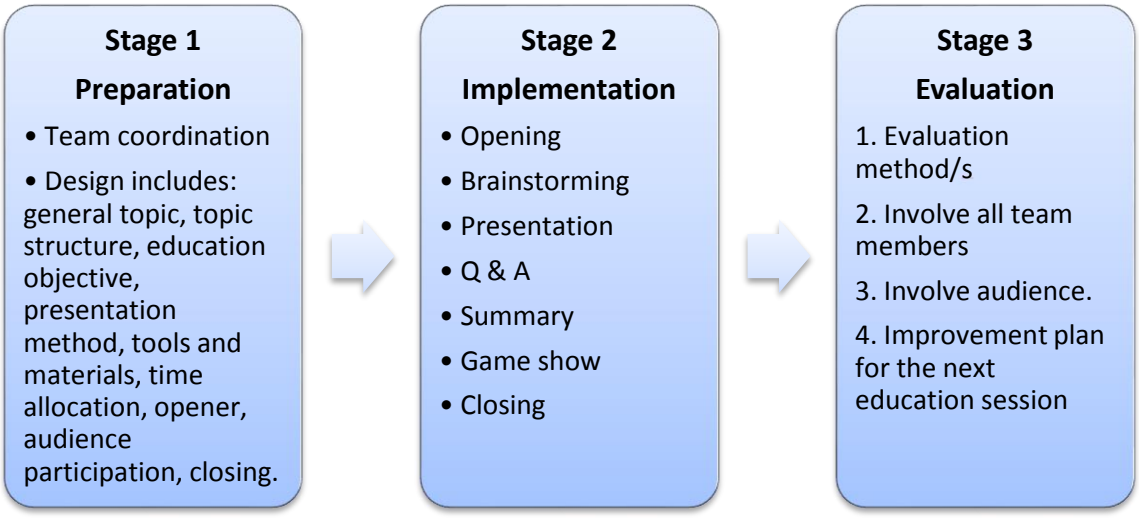
An education session is not simply standing in front of the class and telling ideas to the audience. An education session is a method of communicating where learning can be enhanced by the facilitator's voice, attitude, movement, facial expression and eye contact. All essential knowledge, the sequence of related topics affects audience interest and learning.

2. Objective

The facilitator will be able to explain information to a large group in a relatively short period of time.

3. Stages

There are three stages for planning and conducting an education session – Stage 1-Preparation, Stage 2-Implementation, and Stage 3- Evaluation.



Stage 1	Preparation
	1. Team coordination Strong team coordination is essential for preparation of an education session. First, determine who will be the facilitators/other team members; have a meeting to determine assignments of the team members during the session from the preparation stage to the evaluation stage. Several positions that are usually needed for session are facilitator, assistant, note taker, and organizing committee. **2. Design each education session** The session design includes: • General topic The general topic is the main issue highlighted during the education session. The general topic is made up of other relevant topics, e.g. HIV and AIDS, STI, VCT, domestic violence, etc. These relevant topics fall under the umbrella for "promotion." • Topic substructure *Topic substructure is the detailed content presentation and process order of the topic to be presented during the education session by **determining sub topic orders.** Make a systematic topic structure to help focus the material presentation. A good topic structure will help avoid repetition of the same materials so that the time will be used effectively and efficiently. For example, the general topic is the basic information on HIV and AIDS. The topic structures include detailed information on HIV and AIDS basic information, i.e. definition of HIV and AIDS, the differences and relationship between HIV and AIDS, how HIV works in human body, HIV transmission method, HIV prevention methods, and HIV and AIDS phases in human body.* • Objectives of the education session *Determine the objectives of the education session to be conducted (be specific). This objective(s) will become a success indicator of the education session, so we will know if the session is successful or not – at the end of the session or during the evaluation. The aim of the education session usually includes improvement of knowledge and understanding of a topic.* • Method for presentation Choose the presentation methods by considering the audience's characteristics. A

	variety of methods should be used during the session, not just lecture. Other methods that are participatory can hold audience interest, such as movies, drama, operetta, simulation, etc. Recognize and use various methods to keep the audience focused and involved during the session. • <u>Materials and tools</u> *Prepare the materials and tools a few days before the session so that the facilitator can relax and not feel rushed on the day of the education session.* Prepare materials and tools that are attractive as well as related to the objectives and topics. Learn how to use the materials and tools with practice. Decorate the room but take care not to "over-do" decorations. A cheerful room will create a positive learning environment and help minimize boredom and fatigue among participants. • <u>Timing</u> *Make a plan for time utilization by making a rundown of the education process. This design will help the educator be effective and efficient. Allocate time for each stage of the education. For example:* ○ *Opening: 10 minutes.* ○ *Brainstorming: 5 minutes.* ○ *Basic material presentation: 30 minutes.* ○ *Q & A: 50 minutes.* ○ *Summary: 5 minutes.* ○ *Game show: 10 minutes*. ○ *Closing: 10 minutes.* • <u>How to close the education session</u> An interesting closing will leave the audience with lasting memories. Design the closing so it is memorable. Do not forget to express your appreciation to the audience and remind the audience to applaud themselves too.
Stage 2	**Implementation**
	1. Opening • Use an interesting opener that "grabs attention." An interesting opening will invite the audience to focus on the facilitator. Use provocative questions or statements, an unusual analogy, an interesting example, a personal anecdote, dramatic contrast, an interesting quote, a brief question, a demonstration, or name the latest events that relate with the topic. • There are several things that we do before opening the session:

	○ Avoid the "cold start." Come to the room early and talk informally with participants. Talk informally with participants also helps the facilitator minimize nervousness while warming up his/her voice. ○ A certain level of nervousness is normal, especially right before starting the session. To relax, take a deep breath before starting, inhale and relax muscles, starting from fingers to toes. • Present the objectives to the class (on whiteboard). Tell the audience what they can expect to learn in the session. • Maintain good relations with the audience. A smile leaves a lasting, positive impression on the audience. They are likely to feel more involved in the class if the opening minutes are personal, direct and conversational. Maintain this friendly, open manner from start to close of the session. **2. Brainstorming** • Brainstorming means collecting ideas and opinions from the participants. • Use brainstorming as early as possible as a warm up, for collecting participants' ideas and to involve them early-on in the session. • Another purpose of brainstorming is to assess the knowledge level of the participants on the topic to be presented during the session. **3. Presentation** • Present the content according to your lesson plan. Give key or essential information on the topic and any other relevant information in sequential order. • As noted above, avoid methods that tends to be boring • Present the information clearly, concisely and directly, using the language and terms known by the audience. • Use the materials and tools to enhance understanding. • The facilitator must be aware of time. If time is limited he/she should manage time properly. **4. Q & A** • Q&A gives participants an opportunity to ask questions for clarification or expansion on the topic. Involve the participants in responding to other's questions. • Answer brief, clear and direct statements. Do not use long-winded answers. • Avoid using terminology that is difficult to understand. • Answer in simple, easy to understand sentences. • Remember to ask the audience whether or not their question was answered adequately. **5. Summary** • Briefly summarize the key points of the topic. • The facilitator must manage time. Avoid going over the time allocated for the session.

	6. Game show • Reinforce concepts by using a game show design for the topic. • Several inexpensive prizes can heighten participant's excitement for the game. **7. Closing** • Thank participants and ask them to give themselves a round of applause for their participation. • The education team should stay in the room a few minutes after the session to give so the audience can approach the team for specific information or questions. If the questions are sensitive or embarrassing to ask publically, they will prefer to ask these questions in private. • Remain in the room until all participants leave the room.
Stage 3	**Evaluation**
	1. Evaluation method • There are a lot of methods that can be used for evaluation. Choose a simple method for evaluating the session. • Evaluation of all elements of the session can be performed by team member/s. A focus group discussion is often used so content is discussed in depth. **2. One week after the education, at the latest** • To avoid forgetting what happened during the session, conduct the evaluation no later than the following week. **3. Involve all members of the team** • Involve all team members in the evaluation. All topics and subtopics should be evaluated from the team members. **4. Involve the audience** • If the evaluation is conducted at the close of the session, a short questionnaire (no more than 10 minutes) can be used. • The results of the questionnaire can be used to assess on audience knowledge (if it increased or not. **5. Improvement plant for the next education session** • Use the evaluation results to improve the next education session.

2.3 Edutainment and Sportainment

1. Scope

Edutainment, an acronym for educational entertainment, is entertainment designed to teach something in an entertaining way. Edutainment embeds lessons or information into forms of entertainment to stimulate thought or action. Sportainment is an activity like edutainment that inserts lessons and/or information in a sport activity, e.g., volleyball competition.

Edutainment and sportainment is often used to give a lesson on one or more topics related to socio-cultural attitudes such as behavior change. It creates opportunities to raise taboos or sensitive issues in an acceptable format. Education on drug abuse, family planning, immunization, adolescent pregnancy, HIV/AIDS and cancer is often presented through edutainment/sportainment.

Edutainment/Sportainment – the 9 Ps

1) ***P****ervasive:* edutainment/sportainment can be done anywhere, starting from village festivals, cable TV, songs and dances, drama and talk show.
2) ***P****opular:* people like entertainment and will gladly look for it. They like it and pay attention to its messages.
3) ***P****ersonal:* edutainment engages the audience and allows them draw their own conclusions about character thoughts and actions. The audience may even identify with the character or an action.
4) ***P****articipatory:* the audience willingly participates directly or indirectly. Edutainment may even invite audience participation.
5) ***P****assionate:* edutainment can stir emotions. When this occurs, the activity is memorable; people may talk with others about it and sometimes they change their behavior.
6) ***P****ersuasive:* the person can easily see consequences of their actions. They identify with the characters who become role models. He/she might imitate the behaviors.
7) ***P****ractical:* equipment, venue and actors can easily be obtained. The edutainment can even be done by involving the audience.
8) ***P****rofitable:* when it is thoroughly planned and well managed, edutainment can attract sponsorship for its production, can be repeated and may be profitable for the organizer and actors.
9) ***P****roven effective:* people can increase knowledge, change attitudes and their behaviors.

Edutainment are live performances that include humor and tragedy. Examples include:

- Film and TV programs
- Computer or video games
- Music
- Radio program
- Museum
- Website
- Multimedia software
- Drama/operetta
- Puppet show
- Theater (street)
- Edu-clown (educating clown)

Successful edutainment depends on thorough planning. The format selection is based on audience preferences. Talented actors, an engaging script, appropriate positioning of issues, pre testing, promotion, actor performance, and monitoring and evaluation can all contribute to the event's success. Like edutainment,

sportainment depends on thorough planning and strong coordination. Development of both events is similar.

Edutainment/Sportainment Approach Benefits and Disadvantages

Benefits	Disadvantages (if not planned carefully)
Edutainment/sportainment can: • Point to current thinking HIV and highlight specific issues that affect in specific populations in the community. • Attract and hold attention more effectively than lectures. • Stimulate discussion. • Use the language, slang, etc., of target populations. • Use members of beneficiary populations as actors or as production staff. • Raise sensitive issues such as sexuality, morality and other issues in culturally acceptable ways. • Portray how people might deal with sensitive problems and suggest solutions to those problems • Help alter attitudes and influence social norms.	Edutainment/sportainment may: • Promote stigma and discrimination, for example by portraying certain MARPs (i.e., FSW, MSM, IDU, TG) without compassion • If language is offensive, it may reinforce stigma and discrimination towards MARPs and erect barriers to their acceptance. • If the activity is not realistic, people may dismiss the performance as irrelevant to their lives. • If the focus is on entertainment and not enough on the purpose of the activity, people may miss the objective of the event and miss key messages. • People may tire of a show if it is performed too frequently. • If the audience is not given the opportunity to respond to or discuss the performance, they may go away unsatisfied, and with wrong ideas.

2. Objectives

Many MARPs, especially are difficult to reach through individual or small group direct approaches and there are those who remain "hidden" (socially, culturally, or geographically).

- MARPs will be able to understand and act on information on safer behaviors to reduce STI and HIV transmission risk.

3. Stages

Stage 1	**Preparation**
a.	Form a team. Select/hire a coordinator, someone to handle logistics (where to meet, when to meet, etc.) and also interface with person-in-charge for the event, donors and also stakeholders.
b.	Decide on behavior and communication objectives for the event. Make sure you address what you will want the target populations "TO DO" as a result of seeing your edutainment/sportainment.
c.	Base your event on evidence. A formative assessment or small "listening survey" can gather information for planning the activity. Some issues to explore: 1) the problems associated with HIV/AIDS as identified by the beneficiary population, 2) the different views that the beneficiary populations have towards the problem, 3) the language (phrases, slang, local names for things) that are used to talk about the problem, 4) the solutions generated from the perspective of the beneficiary population, and 5) the specific or traditional kinds of edutainment (drama/theater)/sportainment preferred by beneficiary population.
d.	Develop key messages and use beneficiary language for formulating the key statement/s.
Stage 2	**Development**
a.	Develop the story, sequence and script for the edutainment to make sure that the key messages are conveyed. For sportainment, plan the program in detail including when the moderator communicates the key messages and announces the availability of health services at the venue.
b.	Develop characters and use individual/group activities or exercises to compose the dialogue and action.
c.	Decide if you want to incorporate songs, dances, singing, slogans or other features to highlight certain issues.
d.	Pre-test the script with members of the target population before going further. Do beneficiaries think the activity is appropriate and effective?
Stage 3	**Production**
a.	Rehearse frequently. Pre-test your ideas in front of members of beneficiary populations at various stages of the rehearsal process.
b.	Use feedback to improve the edutainment.
c.	Develop costumes and sets for the edutainment. Consider a "dress rehearsal" with costumes and sets.
d.	Make sure the drama is not too long. Pre-testing should reveal whether your edutainment will hold people's attention.
e.	If your edutainment is interactive/participatory, facilitators should be sure they are well versed in the topic.
Stage 4	**Implementation**
a.	Fix the time, venue and other logistics for the performance(s.) Make sure the location

	is easy for people to reach.
b.	Advertise/promote your performance. Make sure to include dates, times and venue.
c.	Develop a list of stakeholders (politically influential people, donors, potential private sector donors, CBO/NGO/FBO representatives, etc.) and be sure to invite them to the event. Personally deliver invitations. Be prepared to persuade stakeholders to attend this performance. Their presence will make a statement about the importance of the messages for them.
d.	Consider whether you want members of the media to attend and report on the event. If so, develop a list of the specific journalists you want to invite and make sure they come. Special invitations, press releases, or other media-oriented announcements are effective ways to promote attendance.
Stage 5	**Evaluation**
a.	Monitor/evaluate your event. Will you distribute questionnaires to the audience? Or are you going to give a pretest before the event starts and a posttest after the event?
b.	Follow up with any attending media representatives and try to get copies of their coverage.
c.	Follow up with stakeholders (see 4.c.): find out what they thought of the event. Obtain feedback and modify the edutainment work plan if necessary.
d.	Evaluate/report on the effectiveness of the event, how it affected attitudes, knowledge and behaviors of the beneficiary, its entertainment value and use the results for improving the event.

4. Resources, tools and materials

The tools and materials needed to do the edutainment/sportainment include:

- Edutainment or sportainment team
- Theme and key messages to be conveyed
- Script (contains at least the story line, characters, songs if used, slogans, etc.) or agenda for sportainment
- Musical instruments
- Sound system
- Cassettes, CDs, VCDs, and the player
- Trainer, if necessary
- Costumes
- Edutainment/sportainment promotion materials
- Edutainment/sportainment invitations
- Evaluation form
- Reporting form
- Edutainment or sporting venue

Key Resources

USAID SUM Program CD-ROM

- *Edutainment Standard Operating Procedure (SOP)*

2.4 BCC Materials Design and Production

1. Scope

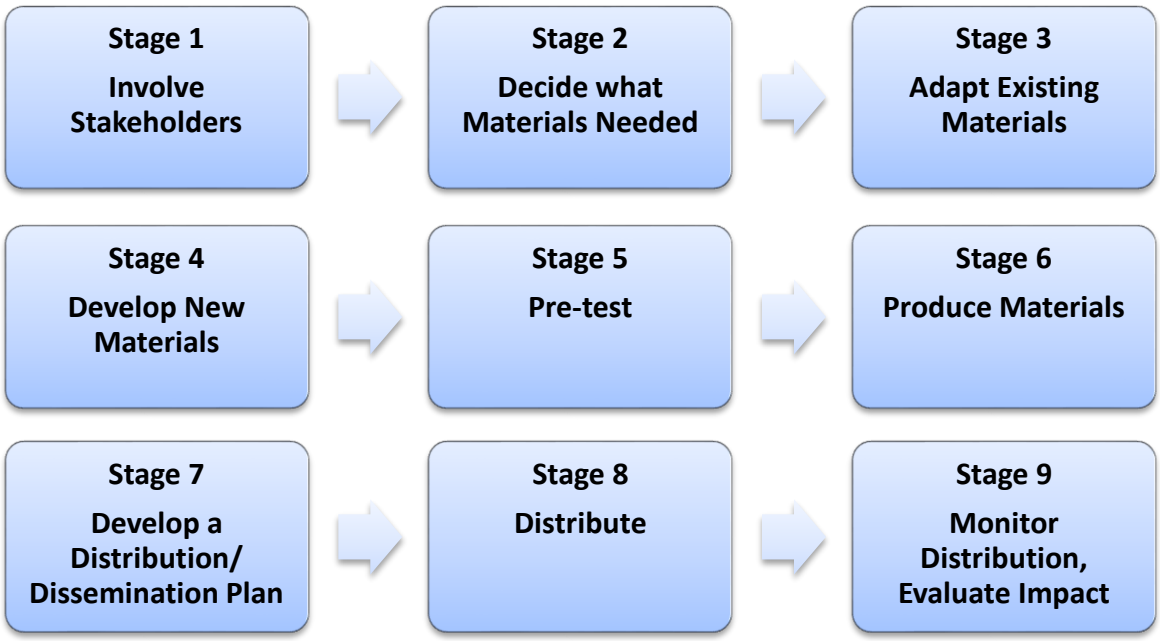
The design and production of communication materials typically occurs after a behavior change communication (BCC) strategy has been developed based on a formative assessment and in consultation with program stakeholders. A well-thought-out BCC strategy should specify the types of materials to be developed and the main messages those materials will promote. It will also link those messages and materials to specific communication and behavioral objectives.

At the very least, key stakeholders such as government representatives, donors, community leaders, and PLHIV should be informed of materials under development and given opportunities to comment on them. This can be done through individual meetings or through creative design workshops. Remember that quality materials make a much better impression while cheaply and unprofessionally made materials can compromise a program.

2. Objectives

- To guide the process of design, production, pre-testing and distribution of BCC materials and to evaluate the output in a systematic way.

3. Stages



Stage 1	Involve Stakeholders
a.	Inform stakeholders of materials development plans at one-on-one

	meetings or in workshops
b.	Include stakeholders in creative design workshops
c.	Involve PLHIV in materials development at every phase
Stage 2	**Decide What Materials are Needed**
a.	Consult formative assessment for guidance on preferred/used channels/materials of beneficiary populations
b.	Choose materials that will best promote the objectives of the BCC strategy for the budget available
c.	Some typical materials for specific beneficiary populations include: ✓ **Clients/Patients** – waiting room posters; take-home pamphlets, flipcharts or cue cards for client-provider interaction ✓ **Healthcare providers** – job aids, reminder leaflets ✓ **Sex workers** – condom reminders, flipcharts for peer educators ✓ **Transport workers** – stickers, audio cassettes, posters ✓ **Youth** – leaflets for events, school posters, comic books ✓ **Wide audiences** – billboards, print/broadcast mass media
Stage 3	**Adapt Existing Materials**
a.	Gather relevant materials to adapt
b.	While technical information and main messages may remain unchanged, modifications in language and localization of images and styles will probably be necessary
c.	Pre-test materials being adapted
Stage 4	**Develop/Design New Materials**
a.	Develop pictorial and textual messages (be as specific as possible) before contacting vendors.
b.	BCC and other relevant technical staff should draft text/copy of print materials as appropriate/possible
c.	Contact three or more vendors to find the one most suitable for the intended production of materials
d.	Draft letters describing the proposed job and include a creative brief and a short paper outlining project needs. The brief should include: expected

	graphic content, messages, color, type of paper, number of copies and project background. Request creative and financial proposals by a certain date from prospective vendors. Request samples of past relevant work.
e.	Hire appropriate vendors (e.g., graphic designers, writers, production vendors)
f.	Make sure all selected vendors have the information needed to do their work, including technical information they may not have access to, sample images, finalized messages, and donor/stakeholder logos.
g.	Pre-test. Get sample materials for pre-testing. Request text and images separately and assembled together. Two-rounds of pre-testing is usually preferable.
h.	Deliver requested changes to vendors after pre-testing
i.	Monitor progress of vendors' work throughout the development process
j.	Always demand to see "proofs" of products to sign off on before final production. For print materials, this may be the very first copy of an item right off the presses to review BEFORE the full print run is executed.
Stage 5	**Pre-Test Materials**
a.	Determine a systematic process/method to gather target audience reactions to messages and materials before they are produced in final form.
b.	Measure the following aspects: • ***Attention***: Does the message attract and/or hold audience's attention? • ***Comprehension***: Is the message clearly understood? Are the main ideas conveyed? • ***Personal Relevance***: Does the target audience perceive the message to be personally relevant? • ***Believability***: Is the message and/or its source perceived as believable? • ***Acceptability***: Is there anything in the message that may be offensive or unacceptable to the target audiences?
c.	Determine the best pre-test method based on resources availability: • *Readability Testing* • *Focus Group Interviews* • *Individual In-depth Interviews* • *Central Location Intercept Interviews*

	• *Self-administered Questionnaire* • *Gatekeeper Review*
Stage 6	**Produce Materials**
a.	Make sure production timing is clear to all concerned parties. Your contract with vendors should include penalties for delays in production.
b.	Coordinate production schedules so that all materials are completed in time for a launch, intervention start, or major event
Stage 7	**Develop a Distribution/Dissemination Plan**
a.	Develop a written distribution/dissemination plan.
b.	Be sure that you have confirmed facilities to store materials prior to distribution.
c.	Get an estimate from the vendor of the approximate size of the materials to be stored (the amount of space they will take up).
d.	Share the plan with parties concerned; include the amount of space required for storage at facilities where materials will be stored.
e.	Develop receipts/forms for recording distribution.
Stage 8	**Disseminate**
a.	Disseminate materials to concerned parties/facilities.
b.	Gather signed records/receipts for materials received.
Stage 9	**Monitor Dissemination and Order More Materials if Necessary**
a.	Maintain contact with distributors to ensure materials are being distributed as planned.
b.	If distributor is actively using materials, request feedback on their effectiveness among beneficiary populations.

Some Tips to Keep in Mind when Designing Materials

- ✓ The lower the literacy level of beneficiary populations, the more emphasis should be placed on pictorial images and the less on text.
- ✓ Messages should be positive and not fear-based.
- ✓ If the materials feature a source, ensure that the source is authoritative and credible for the beneficiary population (doctors, celebrities, officials, traditional healers).
- ✓ Use short and simple text when writing for low-literacy populations.
- ✓ Make sure the main message is repeated within a single material for maximum effect.
- ✓ Be careful not to use language or images that could stigmatize PLHIV. Include PLHIV in the design and review process.
- ✓ Materials should be visually appealing and eye-catching
- ✓ Messages should be presented in ways that are logical and rational, and emotionally compelling.
- ✓ Materials should clearly reflect the reality of everyday lives of beneficiary populations. Use familiar faces, buildings, streetscapes, etc.
- ✓ It should be clear who the beneficiary population is when looking at the materials.
- ✓ Include a call to action.
- ✓ Present one message per illustration/page/graphics. The more white space on a page, the more inviting it is to the eye. The simpler the TV/radio messages, the more likely they will be remembered.
- ✓ Ensure that materials are free of confusing and culturally inappropriate messages and images.
- ✓ Don't be too abstract. Avoid overly sophisticated messages.

4. Resources, tools and materials

- BCC material team (copy writer, art director, etc)
- Formative assessment report
- List of potential MARPs, stakeholders and PLHIV who will be involved in the process of design and production
- Sample of existing materials
- List of material production/printing vendor
- Pre testing tools
- Distribution form
- Receipts form
- M&E tools

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3. Risk Reduction and Behavior Change

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3.1 Individual Risk Assessment (IRA)

1. Scope

Risk assessment refers to the process of determining or quantifying the level of risk of an individual because of certain behaviors. When the risk assessment identifies a person as high risk, a moral obligation requires that the risk assessment be followed by risk reduction efforts.

Individual Risk Assessment (IRA) is an interactive process between a trained facilitator or trained peer facilitator (FC/FW/OW) with one beneficiary, to:

- identify specific behaviors that put him/her at-risk of HIV infection
- help the individual to develop a plan to change her risk behaviors into safer behaviors
- equip the individual with ability and skills that can be used to maintain new behaviors, such as negotiation skills
- help the individual to get services that will enable her to acquire new behaviors, such as clinical services and condom access
- accompany and motivate the individual to access and acquire new planned behaviors.

Two important factors that should be recognized about IRA from the outset:

- Behavior change is complex
- The need to become comfortable discussing personal and sexual issues.

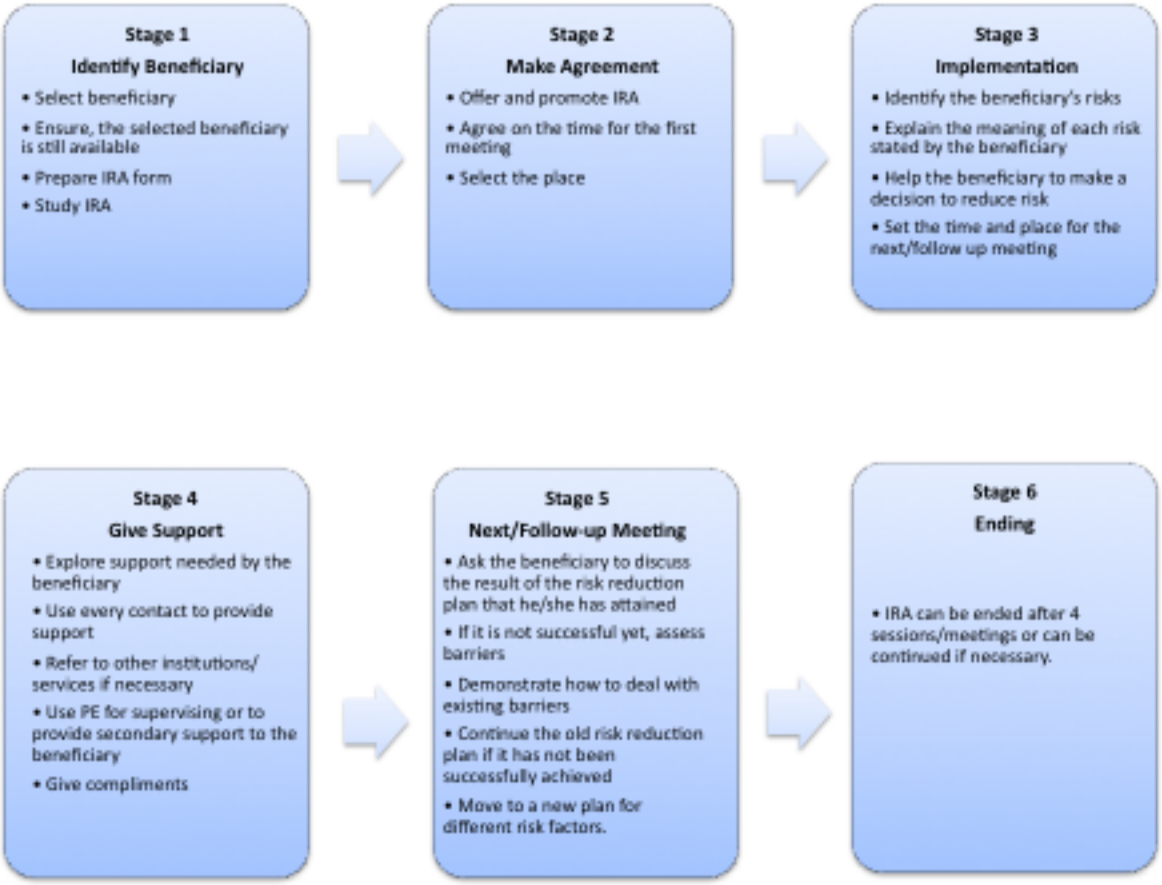
2. Objective

To ensure people with high-risk behavior receive information, non-medical counseling, and skills to help them adopt and maintain new behaviors that will reduce their risk for getting HIV.

3. Basic Principles

- IRA improves the quality of outreach because the discussion/counseling encourages behavior change
- IRA is part of outreach activities
- Individual's risk behavior (possible risk factors are sex without condom, antibiotic consumption behavior, etc.) is discussed
- Offer and discuss potential alternatives to reduce risk
- Provide supporting information and give the client skills to support a risk reduction plan
- Offer clinical services such as STI screening and VCT and include information on the place, price, time and mechanism
- Continually monitor the results of the behavior change plan

4. Stages



Stage 1	Identify Beneficiary
a.	**Select the Beneficiary.** Only those beneficiaries who have received an information package are eligible to enroll for IRA. The complete information package is: 1. Information and discussion on STI and HIV/AIDS including HCT 2. Received a minimum of 1 BCC material along with discussion 3. Prevention material information and discussion (condom and lubricant) 4. Skills on condom negotiation. 5. Information on how to access STI, VCT, CM, PSG and CST services The above information package is supposed to be completed first to ensure that the beneficiary is ready to enroll in IRA. This is because IRA focuses on the risk assessment process, and not on providing information. The IRA focuses on facilitating the

	beneficiary to increase awareness of her risk behaviors and developing a plan to change these into safer behaviors. If the beneficiary has received and understands the complete package of information above in one meeting, then he/she can be enrolled for IRA in the next meeting. Data on the beneficiaries who have received full information package can be obtained from the Data Manager.
b.	**Ensure the selected beneficiary is still available.** Use monitoring and evaluation data.
Stage 2	**Make Agreement**
a.	**Offer/Promote IRA to the Beneficiary.** IRA should be performed on a voluntarily basis; therefore promoting this service is important. The promotion and offer are the initial steps to build the beneficiary's commitment to the IRA process. The information given during the promotion/offer is: 1. The benefits that will be received 2. How IRA is done 3. Commitment required. This consists of the commitment to change behaviors and the commitment to join IRA process.
b.	**Appointment for the first meeting**. At this stage, the outreach worker is not yet required to establish an agenda for the IRA series of sessions. The agenda will be discussed in the second meeting when IRA process is being started. The best time to start IRA depends on the readiness and willingness of the beneficiary. As a general rule, consider carefully time selection to ensure the availability of the beneficiary. Make an agreement to block one hour for each session, which does not affect her working hours.
c.	**Venue selection** The success of the first meeting also depends on the place selected. Choose a place where the distance is not too far; privacy and confidentiality are guaranteed; and is comfortable and accessible. For example a place that is not too far from the beneficiary's home (if the beneficiary wants it); which is not too noisy so that it is easy to talk and be heard; where not many people come in and out of the room so that the beneficiary feels more comfortable to talk; and which is not too hot and does not smell bad; etc.
d.	**Preparing IRA form** A special form for IRA is provided. The form functions as a: 1. Guideline for discussing certain topics during IRA process 2. Documentation on the beneficiary's commitment for behavior that she is going to change 3. Report for IRA activity
e.	**Studying IRA form.** The OW/FC will find it easier to do the risk behavior identification process with the beneficiary if he/she gets familiar with the questions in the IRA form beforehand. One

	form can be used for several meetings.
Stage 3	**Implementation**
a.	**Identify the beneficiary's risks in the last 3 months.** Identify the risks that put the participants at high risk of exposure to HIV. The risk type is grouped into several categories: ▪ Sexual partners, including the numbers of partners and sexual partner variations (client, boy/girlfriend, regular partner, etc.) ▪ Condom with lubricant use, including not using condoms, using condom but inconsistently. ▪ Sexual behaviors, including the risks caused by sexual behaviors such as anal sex, vaginal sex, oral sex and using sex toys. ▪ Type of lubricants, including habits of using non water-based lubricants. ▪ Health care, including health-seeking behaviors, from never to having health checks to having health checks but not routinely. ▪ Adherence in taking medicine, including STI medicine, from not taking the medicine to taking the medicine without paying attention to the doctor's instruction. ▪ Self medication, including the risks of self medication, from taking antibiotics without the doctor's prescription, frequent vaginal douching to using traditional medication (traditional healer, taking herbal medicine, etc.). ▪ Alcohol and drug use, including habits of consuming alcohol and drugs individually or in relation to sexual behaviors (alcohol/drugs consumption before having sex or with sexual partners). All behaviors identified here are those that put people at risk. The facilitator needs to probe into the beneficiary's risks, to identify priorities and develop a risk reduction plan.
b.	**Explain the meaning of each risk stated by the beneficiary.** After all risks have been identified, the FC/OW should explain the meaning of each risk and why it is a risk. This session summarizes and clarifies risk in case there are still any doubts or questions about the information received. The FC/OW should give the opportunity for questions and answers during this explanation session. The explanation should be based on scientific facts and not just general knowledge. If it is possible, FC/OW should invite the participant to discuss the single biggest risk faced and agree on its risk reduction plan. One thing should be kept in mind: do not judge the beneficiary's behavior.
c.	**Help the beneficiary to make a decision on the risk reduction plan to be implemented.** The main principle is to make a staged and realistic risk reduction plan. If possible, it starts with the easiest risk to change. The risk reduction plan should cover 3 months, depending on beneficiary's risk group, and should be realistic for that period of time. Determine at most 3 risk reduction goals. A risk reduction plan with many goals,

	drastic changes and with a long duration for completion is likely to fail. The facilitator can "guide" the beneficiary if the risk reduction plan is realistic in terms of the participant's ability.
d.	**Set the time and place for the next/follow-up meeting.** The purpose of next/follow-up meeting is to look at progress on the agreed risk reduction plan. A different place can be proposed but the most important thing is that the place should be comfortable for a discussion. The follow-up meeting should be within 1-4 weeks after the first meeting. Give the beneficiary a brief description on what will be done/discussed in the follow up meeting.
Stage 4	**Give Support**
a.	**Explore what support the beneficiary needs.** When a risk reduction plan is agreed, the FC/OW should explore what support the beneficiary needs to achieve the risk reduction plan. The support should be realistic, the FC/OW should consider whether the support can be given or not. Be prepared for further requests/needs from the participant such as referral to other institutions. Therefore, the facilitator should prepare lists of various services that have been mapped (address, contact, type of service, fees, procedure, etc.). Support can include: • Maintaining contact with the beneficiary and asking about his/her progress or problems. • Give compliments on the participant's success. • Provide safe sex package (SSP). • Provide other reading materials to motivate the participant. • Ask questions/give positive feedback when the beneficiary does not carry out the risk reduction plan seriously. • Refer the participant to the health service or other institution. • Ask PE to become mentor or indirect supervisor. • Persuade the participant's partner or people who have close relationships with the participant to support the behavior change efforts, etc. The facilitator should remember that not all participants want similar forms of support.
b.	**Use every contact to give support.** Use every contact outside the IRA formal meeting to support the beneficiary. This is because the FC/OW never knows when he/she will have contact with the beneficiary except when he/she has made appointment with the beneficiary. Through this contact, the FC/OW can maintain the beneficiary's enthusiasm so that the beneficiary will not avoid FC/OW meetings. Behavior change always needs support, not only motivation from within. If the support requested is too difficult for the FC/OW, then the FC/OW needs to try and provide support in smaller ways, so as not reject the

	beneficiary.
c.	**Refer to other institution/service if necessary.** If the FC/OW cannot facilitate the support asked by the beneficiary directly, it is better to prepare alternative referral services.
d.	**Use PE for "supervising" or to give secondary support.** An experienced PE makes the best program partner to monitor the effort and difficulties faced in the beneficiary risk reduction plan. An experienced PE can also be asked to give support for the beneficiary in addition to the FC/PW support. If the FC/OW is not sure of the PE's ability, it is better not to ask them to do this. Being monitored or helped by a peer is not always positive and fun.
e.	**Compliment.** Motivating behavior change is more of an art than a mechanical technique. It is important that the FC/OW recognizes and compliments a beneficiary's achievements against the risk reduction plan, no matter how small the achievement may be.
Stage 5	**Next/Follow Up Meeting**
a.	**Invite the beneficiary to discuss her/his risk reduction plan achievements.** Use the previous risk reduction plan meeting as the baseline to assess the ongoing behavior change. To compare, a special column is available in the IRA form. Ask the beneficiary to state her/his achievements. Perform achievement status assessment for each risk reduction (there are 3). Once more, be encouraging and compliment the beneficiary's success, however small, to keep them motivated and willing to do better in the future.
b.	**If the plan has not been successful, assess the barriers.** When the risk reduction plan has not been successful, the barriers can be recorded in a special column provided (in the IRA form). Usually there will be many reasons given by the participant on why he/she cannot reach the risk reduction plan target. FC/OW needs to identify the most important barrier, which, if it is eliminated, will make the behavior change easier.
c.	**Demonstrate how to deal with the existing barriers.** Once the most important barrier is identified, the FC/OW needs to discuss carefully all possible ways to deal with it. Ask the beneficiary's opinion first, then give your opinion to reach agreement on the next risk reduction plan. If this difficulty is too big and seems like beyond the reach of the beneficiary and your authority, divide the difficulty into smaller steps so that it will be more realistic to be achieved. If it is still not possible, then offer another risk reduction plan based on other risks identified in the previous meeting.
d.	**Continue the unsuccessful risk reduction plan.** Each unsuccessful risk reduction plan needs to be prioritized as the next risk reduction plan. It is very important not to shift to a new risk reduction plan before the previous plan shows success. If this principle is ignored, the beneficiary will get used to shifting from one risk reduction plan to another. The main reason for doing IRA is to help the beneficiary to deal with her risks, one by one, using the methods that he/she thinks

	appropriate.
e.	**Move to a new plan with different risk factors.** When a risk reduction plan is successful, the FC/OW needs to guide the beneficiary to move on to another risk reduction plan based on a different risk in the follow-up meeting. The FC/OW needs to refresh the participant's memory on the risks that have been identified in the previous meeting, re-explain why those behaviors are risky and discuss the risk reduction plan options. Moving to a new plan in effect can also mean moving on to a higher risk reduction plan for the same risk factor. For example, the beneficiary's risk may have been identified as never using a condom. The first risk reduction plan may be to try using condoms. When this plan is successful and the beneficiary has gained a positive impression on condom use, the same risk category (condom use) can be used with an increased risk reduction plan target, such as trying to use a condom consistently with all clients for one month.
Stage 6	**Ending IRA**
a.	**When can IRA be ended?** Ideally, the IRA session is ended when all risk factors/categories identified for a beneficiary have been successfully reduced or eliminated. However, this often needs a very long time and the beneficiary may lose interest. Besides, IRA does not and should not last forever if we refer to the targets that we have in our program. Therefore, IRA can be ended after a minimum of 4 meetings. The frequency of meetings can range from once a week (the most frequent) to once a month (the least frequent). One or more risk is manageable in this timeframe.
Stage 7	**Activity Monitoring**
a.	Decide on what aspects are to be monitored in this activity. In general, several aspects that are monitored by the program are: • Number of beneficiaries that follow IRA activities • Number of IRA participants who have been successful with his/her risk reduction plan • Average number of risk reduction interventions that have been successful • Number of IRA beneficiaries referred to STI and VCT services • Number of IRA beneficiaries who access STI and VCT services • Beneficiary's satisfaction towards the IRA service provided by the NGO • Benefits and barriers of the activity from the beneficiary's point of view
b.	**Determine the methods to be used in monitoring.** Determine whether monitoring will only analyze program data or whether it will include other additional methods such as: • In-depth interview with the beneficiaries and their regular partner/s • FGD

	• Exit interview to assess the satisfaction of regular partner after receiving health service • Survey
c.	**Decide who will do this monitoring**. In qualitative monitoring, if the monitoring staff is the program implementing staff, several arrangements are needed to avoid bias, such as using program staff from other areas.
d.	**Determine when the monitoring will be done.** Monitoring should be done regularly. Monitoring that is based on program data should be done every month while qualitative monitoring should be done once every 6 months or once a year.

Notes

Anticipated difficulties

The facilitator (FC/FW/OW) does not get data on the beneficiaries and where he/she can find the beneficiaries who have received a complete outreach package. So that it is difficult to prioritize the participants. If this happens, IRA cannot be started until the data is obtained.

IRA Targets

How many people need to follow IRA? During the program, at least 60% of the beneficiaries who have received the complete outreach package should follow either IRA or GRA.

From IRA to GRA or from GRA to IRA?

No problem. Beneficiaries can use both assessments. Several GRA participants have performed IRA previously. Several beneficiaries who have performed IRA, have also joined GRA. Because there are often risks that cannot be managed by the beneficiary on her own, they can follow GRA. Likewise, the participant can have a chance to continue her risk reduction plan or other risk reduction plan that has not been discussed during GRA.

Note: There is no certain order that makes a beneficiary eligible for IRA or GRA. So a person who has joined GRA does not need to, but may do IRA before GRA or vice versa.

5. Resources, tools and materials

- Outreach report/database
- List of MARP target
- IRA form
- Referral card
- Various type of IEC materials
- Condom and lube
- Dildo

Key Resources

USAID SUM Program CD-ROM

- *IRA Standard Operating Procedure (SOP)*

3.2 Group Risk Assessment

1. Scope

In public health, risk assessment refers to a process to determine or quantify the level of risk for an individual or population due to certain behaviors.

Group Risk Assessment (GRA) is an interactive process between a facilitator or trained peer-facilitator (Field Coordinator/ Field Worker/ Outreach Worker/ Peer Educator) and several beneficiaries to help them identify specific behaviors that place them at risk for HIV and other STI. GRA also helps beneficiaries to make a behavior change plan to reduce risk.

GRA is also aimed at helping the beneficiaries to access other prevention services as needed, either in clinical or community settings. A referral network to key services should be established by the CBO prior to starting GRA. (See section on referral network for CBOs)

GRA involves several sessions during a certain time period (for example once a week for one month). Ideally, each participant attends every session. The number of GRA participants should be relatively small (2-8 persons) to be most effective.

Basic skills to be mastered by a GRA facilitator:

- Communication skills: verbal and non-verbal techniques, building and supporting consensus, active listening, and skills to organize questions and answer sessions.
- Facilitating skills: developing and organizing ideas, supporting beneficiary's decision making, managing conflict, encouraging active group participation, skills to open and end meetings.
- Comprehensive knowledge of HIV and other STI transmission and prevention, particularly of different options to reduce risk.
- Comprehensive knowledge of steps for behavior change.

GRA is usually carried out separately from a support group, because GRA sessions are based on a pre-established curriculum and on specific behavior outcomes that will be developed and monitored. However, GRA could be performed as part of a support group's activities.
GRA is generally "open" to other participants, although in practice it tends to be "closed" based on the participants' preferences. Support groups tend to be "closed" to new members or, at least, members are not allowed to join or to quit the group freely without any agreement from existing members.

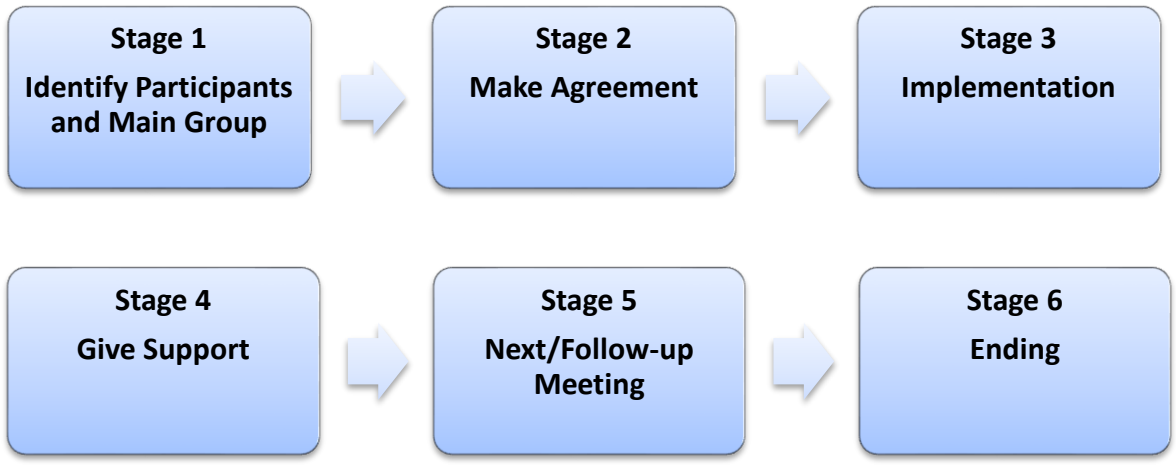
2. Objective

To ensure that persons at high risk receive non-medical counseling and skills that help them to adopt and maintain new behaviors in order to decrease their risk for HIV.

3. Principles

- To take advantage of main social group or network's strength in identifying risks, determine how many participants are exposed to these risks; suggest safer behaviors and how to maintain them.
- GRA participation is voluntary in nature, with a view to enabling participants to manage their risks.
- Use the social network of selected beneficiaries to identify and recruit new GRA participants.
- The characteristics of the main group are that participants tend to be friends, tend to spend time together in their daily activities and meet each other often.
- The group should not be too big, ideally 2-8 persons, up to 12 persons.
- The group must have a pre-defined time limit for its existence, and it is better if the same participants always attend each meeting.

4. Stages



Stage 1	Indentify Participants and Main Group
a.	**Determine which beneficiaries may become GRA participants in each intervention location.** The only eligible beneficiaries are those who have been reached with a complete information package, i.e.: • STI & HIV information, including VCT information • IEC media distribution including discussion/information sharing

	• Prevention materials distribution as well as discussion/information sharing • Information and skills on condom negotiation including other safe sex alternatives • Information on how to access services (STI, HCT, CM, PSG, CST) **Note:** GRA is a risk assessment process that is not focused on giving information but more on how to make the participants realize risk behaviors and make a common plan to make their risk behaviors safer. To reach this stage and to create openness among participants during the GRA sessions, only participants who have already received all basic information can follow the GRA. The FHI data manager or monitoring evaluation unit can help by providing information on which beneficiaries have received complete outreach package. However, it is okay to share information again during the initial GRA meeting as a refresher before entering risk assessment.
b.	**Prioritize which participants will be included into GRA first.** Prioritize which beneficiaries, which locations and when the GRA will be held. Do it in stages because perhaps not all eligible beneficiaries can be included in the GRA process at the same time.
c.	**Make sure that the priority participants are still in the area.** Make sure that the identified candidates are still available in the area and have not moved away.
d.	**Observe participant main group.** Observe the members of the main group and their social network/ support network. Note several important points, such as: - What is the reason for creating the group? What are the bonds (origin, room location, hobby, and others)? - Are there any group rules? (that influence the participant's life, either as an individual or as a group). For example, MSM groups are egalitarian and develop their own group rules. - How was the rule developed? Does everyone in the group follow the rule? - Is there any social sanction for the group member who breaks the group rule? - What is the strength of the group that can be used as the basis for the behavior change? - Who is the dominant person in this group?
Stage 2	**Determine Time and Place**
a.	**Offer/promote GRA to priority participants.** GRA is voluntary; therefore, offer and promotion are important elements. **Note:** Participants need to know the tentative schedule, who will be involved during the GRA process, what will be done, what commitment is needed from the participants and benefits that participants will receive by following the GRA. Make sure that at least 2 people can join GRA and the maximum number is 8 persons. If there is only one person who is interested, do IRA. If there are more than 8 persons

	interested in GRA, divide them into two or more.
b.	**Agree on the time of the meeting or GRA implementation with the participants.** Choose a time when every participant is able to come and with a quite long duration (about 1 hour). Choose a time that does not disturb their main activity/income. **Note:** When the GRA participants have been recruited, discuss and agree on the schedule for the first meeting. At this stage, OW does not have to make an agreement on the whole schedule because this will be discussed during the first meeting. It is important to accommodate the participants' aspirations in this first meeting. There is no best time to start GRA. It depends on the field condition.
c.	**Determine adequate place for doing the GRA.** The key for a successful first meeting depends on the choice of the place. **Note:** The criteria for a suitable place depend on the field standard and will be different for every location. Choose a place which is not too far and where privacy, confidentiality and quietness can be maintained. The place should be near to where the participants live, and big enough for all participants, and without people coming and going. It should be clean, and not noisy, hot or smelly. A drop-in center (DiC) could be suitable for GRA meetings.
d.	**Provide necessary logistics.** **Note:** The logistics include snacks and other supporting materials. For the first meeting, provide the snacks as needed. For the next meetings, it is important to reach an agreement with the participants on how they will provide the logistics. Tell them that the organization cannot pay for logistic needs during all meetings, but it is willing to share the cost with all participants.
Stage 3	**GRA Implementation**
a.	**Prepare the GRA form.** **Note:** To make the GRA process easier, a special form is provided. This form is used for GRA activity report as well as a guide on what should be discussed during the GRA session. Knowing the form and questions will make the GRA participant risk identification easier. One form can be used for several GRA meetings.
b.	**Identify participant risks in the last 3 months.** The risks identified are certain behaviors that place the participants at high risk for HIV. The type of the risk is categorized into: ▪ Sexual partner, related to the risks caused by the number of sexual partners and variation of sexual partners (client, boy/girlfriend, regular partner, etc.) ▪ Condom and lubricant use, including not using condoms, until using condom but inconsistently.

	▪ Sexual behavior, related to the risk caused by the sexual behaviors such as anal sex, vaginal sex, oral sex and using sex toys. ▪ Types of lubricants, including using various types of non water-based lubricant. ▪ Health examination, including health-seeking behavior situation from never having health check to having a health check but not routinely. ▪ Not knowing his current HIV status: not going to VCT ▪ Adherence in taking medicine, including STI medicine, from not taking the medicine to taking the medicine without paying attention to the doctor's instruction. ▪ Self medication, including the risks of self medication, from taking antibiotics without the doctor's prescription, frequent vaginal douching to using traditional medication (traditional healer, taking herbal medicine, etc.). ▪ Alcohol and drug use, including the habits of consuming alcohol and drugs individually or in combination with sexual behaviors (alcohol/drugs consumption before having sex or with sexual partners) ▪ In addition, the following can be problems: self-confidence, self-esteem, stress and depression, stigma and discrimination… **Note:** All behaviors identified here are those that put people at risk. The facilitator needs to probe into the beneficiary's risks to identify priorities and develop a risk reduction plan.
c.	**Explain the meaning of each risk, why it is a risk behavior.** **Note:** After all risks have been identified the FC/OW should explain the meaning of each risk and why it is a risk. This session summarizes and clarifies risk in case there are still any doubts or questions about the information received. The FC/OW should give the opportunity for questions and answers during this explanation session. The explanation should be based on scientific facts and not just general knowledge. If it is possible, FC/OW should invite the participant to discuss the single biggest risk faced and agree on its risk reduction plan. One thing should be kept in mind: do not judge the beneficiary's behavior.
d.	**Agree on the risk reduction plan that the participants want to do related to the identified risk behaviors.** Determine a maximum of 3 risk reduction plans for each person or each group if majority risks are found. **Notes:** The main principle in making a risk reduction plan is to make a realistic and step-by-step plan. If it is possible, start with the biggest risk that the participants have. All risk reduction plan should have at most 1 month to complete. The risk reduction plan should be realistic enough to be completed within the predetermined time period. A risk reduction plan that has many targets, is over-ambitious or has a long duration tends to be unsuccessful. To a certain extent, the facilitator can "guide" the GRA participant risk reduction plan to make it realistic according to the participants'

	ability.
e.	**Determine the time and place for the next/follow up meetings.** At the end of the GRA session, agree on the time and place for the next meeting to review progress against the agreed risk reduction plan. **Note:** A different place might increase participant's motivation to keep attending the meeting. The follow up meeting should not be more than 1 month after the previous meeting. It is also good to give a brief description on what the group will do in the follow up meeting.
Stage 4	**Give Support**
a.	**Explore what kinds of support the participants need in carrying out the risk reduction plan and how the participants want the support to be given (this step done between meetings).** **Note:** Although support will be given between the scheduled GRA meetings, during the GRA, and in the agreed risk reduction plan, the facilitator should explore participants' needs for support so that he/she can carry out the agreed risk reduction plan e.g., further knowledge on options to reduce risks, skills such as negotiation skills or communicating with health care providers Even though the facilitator may offer support, he/she has to be realistic about what support can be given. Be prepared for requests for extra support from participants, by showing that indirect support in the form of referral to other institutions can be given. Therefore, the facilitator needs to be ready with the list of various services that have been mapped (address, contacts, types of services, fees, procedure, etc). Support can include: • Maintaining contact with the beneficiary and asking about his/her progress or problems. • Give compliment on the participant's success. • Provide SSP. • Provide other reading materials to motivate the participant. • Ask question/give positive feedback when the beneficiary does not implement the risk reduction plan seriously. • Refer the participant to the health service or other institution. • Ask PE to become mentor or indirect supervisor. • Persuade the participant's partner or people who have close relationships with the participant to support the behavior change efforts, etc. The facilitator should remember that not all participants want similar forms of support. Sharing experiences on reducing risks and addressing barriers to reduce risks among the participants is also crucial. Allocate enough time for this session.

b.	**Use every contact to give support.** Use every contact outside the GRA formal meeting to support the beneficiary. **Note:** You never know when you will have contact with the beneficiary again except if you make appointment with him/her. Therefore, the support should be maximized each time you contact the participant, either individually or in groups. Behavior change always needs supports, not only motivation from within. If the support requested is too difficult to provide, then try to provide support in smaller ways, so as not reject the beneficiary.
c.	**Refer to other institutions/services if necessary.** If you cannot facilitate the support asked by the beneficiary directly, prepare alternative referral services.
d.	**Use PE for "supervising" or to give secondary support.** An experienced PE makes the best program partner to monitor the effort and difficulties faced in the beneficiary risk reduction plan. An experienced PE can also be asked to give support for the beneficiary as an addition to the FC/PW support. If the FC/OW is not sure of the PE's ability, it is better not to ask them to do this. Being monitored or helped by a peer is not always appropriate. Be sure that PE does not give contradictory messages.
e.	**Give group compliments in terms of implementing risk reduction plan.** You can use any opportunity for motivating or maintaining participants' focus on their risk reduction and behavior change plan. **Note:** Motivating behavior change is more of an art than a mechanical technique. It is important to show appreciation and give compliments for any achievement against the risk reduction plan, no matter how small the achievement may be.
Stage 5	**Next/Follow Up Meeting**
a.	**In next formal GRA meeting, determine the results/achievement against the risk reduction plan discussed in the previous meeting.** The main agenda of the next/follow up GRA meeting is to discuss the results or achievement against the agreed risk reduction plan from the previous meeting. **Note:** To compare, a special column is provided in the GRA form. Perform achievement status assessment for each participant and each risk reduction. Once more, give compliments and recognition of the participant's success, however small. It is important to keep them motivated and make them willing to do better in the future.
b.	**If the plan has not been successful, assess the barriers.** When the risk reduction plan has not been successful, the barriers can be recorded in a special column provided in the GRA form. **Note:** In general, there will be many reasons given by the participants on why they

	could not realize the reduction plan target. The facilitator needs to choose the most important barrier, which, if it is eliminated, will make the behavior change easier.
c.	**Demonstrate how to deal with the difficulties.** Once the most important barrier is identified, the facilitator needs to discuss carefully all potential ways to deal with it. **Note:** Ask the participant's opinion first then give your suggestion(s) to reach agreement on the next risk reduction plan. If this difficulty is too big and seems beyond the participant's and your authority, divide the difficulty into smaller parts so that it will be more realistic. If it is still not possible, you need to offer another risk reduction plan from among the other risks identified in the previous meeting.
d.	**Continue the unsuccessful risk reduction plan.** Each unsuccessful risk reduction plan needs to be prioritized as the next risk reduction plan. **Note:** It is very important not to shift to a new risk reduction plan before the previous plan shows success. If this principle is ignored, the participant will get used to shifting from one risk reduction plan to another. The main reason for doing GRA is to help participants deal with their risks, one by one, using the methods that they think are appropriate.
e.	**Move to a new plan with different risk factors.** When a risk reduction plan is successful, the facilitator needs to guide the beneficiary to move into another risk reduction plan based on a different risk in the follow up meeting. **Note:** The facilitator needs to refresh the participants' memory on the risks that were identified in the previous meeting, re-explain why those behaviors are risky and discuss the risk reduction plan options. Moving to a new plan in effect can also mean moving on to a higher risk reduction plan for the same risk factor. For example, the beneficiaries' risk may have been identified as never using a condom. The first risk reduction plan may be to try using condoms. When this plan is successful and the beneficiaries have gained a positive impression on condom use, the same risk category (condom use) can be used with an increased risk reduction plan target, such as trying to use a condom consistently with all clients for one month.
Stage 6	**Ending**
a.	**End the GRA process when all identified risk factors/categories for participants have been reduced or handled successfully.** **Note:** Ideally, the GRA session is ended when all risk factors/categories identified have been successfully reduced or eliminated. However, this often needs a very long time and beneficiaries may lose interest. Therefore, GRA can be ended when at least 1 risk reduction plan has been executed successfully. To help beneficiaries achieve the goal,

	GRA should be designed based on limited duration. A GRA does not and should not go on forever. In general, there will be 1-3 meetings. The frequency of meetings can range between once a week (the most frequent) to once a month (the least frequent). In this duration, at least one or more risk can be managed.
b.	**Rolling: ending by starting.** Even though a GRA has completed and been disbanded, another GRA is usually needed to address other risks. **Note:** The new GRA should maintain one or two old members. If there are 4 old members, make 2 GRA groups with 2 old members in each group plus several new members or 4 GRAs with one old participant in the group plus one or more new members. This approach has two advantages: 1) an old participant who has not managed all his/her risks can continue the risk reduction plan with the new situation without being bored, 2) recruitment of new members increases coverage. The difficulty of this model is that the facilitator should be sure that the new participants are still in the old members' social network and the risks to be dealt with are similar.
Stage 7	**Activity Monitoring**
a.	**Decide on what aspects are to be monitored in this activity.** Several aspects that are generally monitored by the program are: • Number of beneficiaries that follow GRA activities • Number of GRA participants who have been successful with his/her risk reduction plan • Average number of risk reductions that has been successful • Number of GRA beneficiaries referred to STI and VCT services • Number of GRA beneficiaries who access STI and VCT services • Beneficiaries' satisfaction towards the GRA service provided by the NGO • Benefits and barriers of the activity from the beneficiaries' point of view
b.	**Decide on monitoring methods to be used.** Determine whether monitoring will only analyze program data or whether it will include other additional methods, such as: • In-depth interview with the beneficiaries and their regular partner/s • FGD • Exit interview to assess the satisfaction of regular partner after receiving health service • Survey
c.	**Decide on who will do this monitoring.** In qualitative monitoring, if the monitoring staff is the program implementing staff, several arrangements are needed to avoid bias, such as using program staff from other areas.

d.	**Determine when the monitoring will be done.** Monitoring should be done regularly. Monitoring that is based on program data should be done every month while the qualitative monitoring should be done once every 6 months or once a year.

Notes

Anticipated difficulties

- The facilitator (FC/FW/OW) does not get data on the beneficiaries and where they can find beneficiaries who have received complete outreach package so that it is difficult to prioritize the participants. If this happens, GRA cannot be started until the data is received.
- Not all participants who have received complete outreach package belong to the same main social network. If this is the case, the GRA can still be done as long as most of the members are from the same main social network.
- Problems with the location and logistics may reduce a participants' motivation to follow GRA.

GRA Targets

How many people need to follow GRA? The GRA target is at least 30% of beneficiaries who have received the complete outreach package should follow GRA/IRA during the program.

How many times a beneficiary should attend GRA meeting?

GRA is ended at the third meeting (however, it can be continued if participants wish). If in a GRA group the members are always changing, the new person/member should be counted since the initial meeting (how many times he/she has joined GRA meeting). So it is possible that GRA participants do not reach the three meetings at the same time. It is expected that by the third meeting, three agreed plans can be realized.

From IRA to GRA or from GRA to IRA?

No problem. Beneficiaries can use both assessments. Several GRA participants have performed IRA previously. Several beneficiaries who have performed IRA, have also joined GRA. Because there are often risks that cannot be managed by the beneficiary on her own, they can follow GRA. Likewise, the participant can have a chance to continue her risk reduction plan or other risk reduction plan that has not been discussed during GRA.

Note: There is no certain order that makes a beneficiary eligible for IRA or GRA. So a person who has joined GRA does not need to, but may do IRA before GRA or vice versa.

5. Resources, tools and materials

- Outreach report/database
- List of MARP target (social network support group/core group)
- GRA form
- Referral card
- Various type of IEC materials
- Condom and lube
- Dildo

Key Resources

USAID SUM Program CD-ROM

- *GRA Standard Operating Procedure (SOP)*

3.3 Condom Social Marketing and Management

1. Scope

The management of condom and lubricant supply chain includes:

1. Preparation and needs assessment on the types of condom and number of condoms that should be provided to each seller, each house/hotspot and stored in the working group 'warehouse'
2. Management of supplies from various sources: Health Office, Family Planning Board, National AIDS Commission, INGO, condom producer, etc.
3. Storage management
4. Distribution management from the working group to the seller and house owner
5. Mechanism of promotion and selling of supplies from the seller and massage parlor owner/manager to the MSW and their clients. Often the manager of condom outlets (mobile outlets) also functions as a peer educator and promotes and sells condoms to MSM.
6. Mechanism for monitoring inventory and re-stock
7. Financial management
8. Record and reporting system

2. Objectives

- To reduce high-risk behavior and to promote healthy lifestyle through condom use.
- To improve supply chain system and management (including distribution) of condom and lubricant and guarantee that condom and lubricant are available and affordable at all times in sufficient amounts in the intervention location, down to the smallest unit, i.e., in each house down to each room.

Waria and Condom Use

Many Waria have multiple sexual partners, and 80% in Surabaya sell sex. However, Waria have little power to demand condoms in sex work. The CSO engages in intense outreach education to Waria sex workers to educate them about safer sex. They feel that awareness of STIs and condom use has increased and they have seen a decrease in the prevalence of STIs among Waria.

Preferences were important in getting Waria to use condoms consistently. Some prefer condoms that they need to purchase over the ones that are provided free. They calculated the amount of condoms needed so that Waria could not use the excuse that there were no condoms available. They provide condoms through an outreach worker at hotspots. Outreach workers spread the word if a client is refusing to use condoms and the Waria sex workers will refuse to have sex with him.

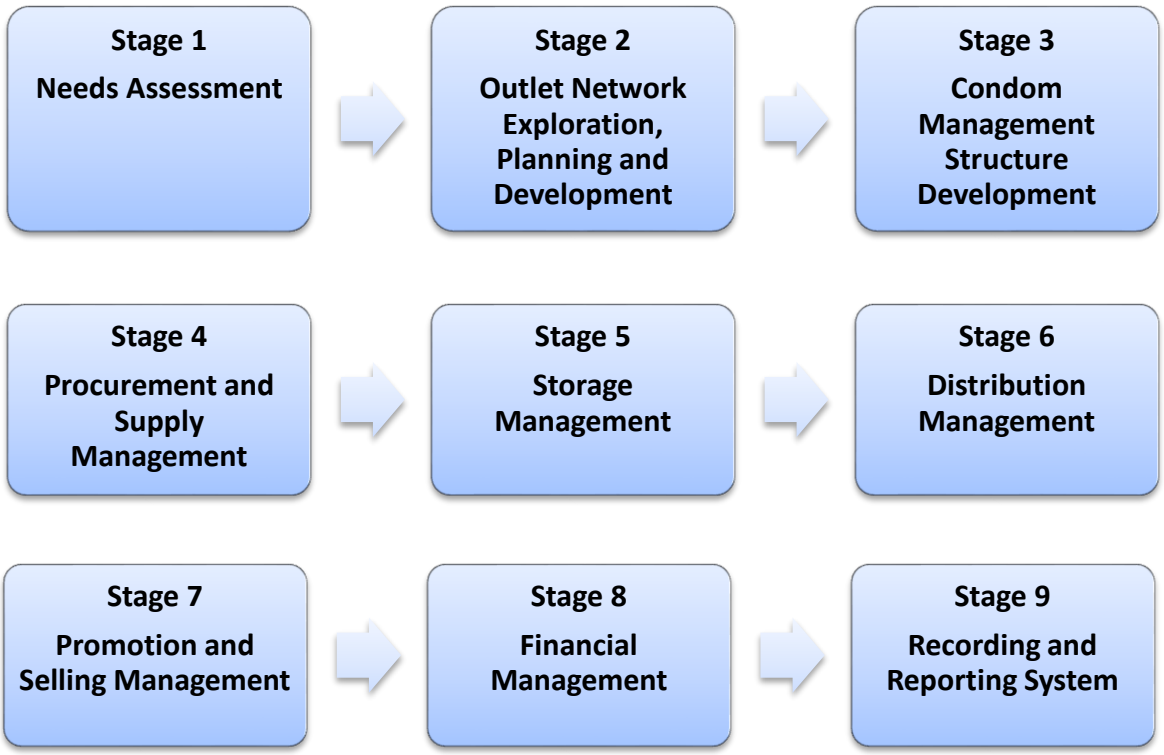
3. Principles

- Availability:

- The product is easily accessible where users are located
- Use existing distribution channels

- Easy access:
  - Opportunity to educate users and create demands for the product
  - Product can be accessed anytime it is needed
- Price affordability:
  - The price should be reasonably priced for the poorest community
  - Relate to the smallest and most frequently used bank note or coin.
- Attractiveness:
  - Interesting packaging
  - Brand is easy to remember
  - A promotion for "What first comes to mind"
  - Meet quality standards

4. Stages



Stage 1	Needs Assessment

a.	Estimation of the number of condoms and lubricants needed. • Low, high and average estimations should be calculated • Number of condoms and lubricants need to be estimated separately since condoms are disposed of after each sex act, whereas, lubricant can last over several times. • Calculation should be performed every week so that it becomes easier to estimate; then multiply the result by 4 weeks to calculate the need by month • The easiest way to calculate this estimation is by using a simple formula: ○ **Number of beneficiaries x number of sex transactions per week x 4 weeks**
b.	Confirm the need with the beneficiaries and community. • In reality, the formula above does not apply uniformly for each location and beneficiary group. To get more accurate calculation, conduct interviews or FGD with the beneficiaries and community to confirm need. • Remember there is an urgency for meeting condom and lubricant needs for each high-risk population. Condoms are the first priority for all and then followed by lubricants as the next priority.
c.	Identify the preferred type and brand of condom and lubricant: • Types or condom are: with or without lubricant, with or without aroma, with or without texture, three-in-one package or more, etc. • Types of lubricant: brands, types of package, size of package, quality of the lubricant. • Observe which condoms and lubricants are distributed the most currently at the location. Interview or FGD with beneficiaries to check this.
c.	Perform periodic needs assessment • To anticipate changes, repeat the assessment process every 6 months or every year.
d.	Perform assessment in all intervention locations. • Perform the needs assessment in all locations so that the overall situation can be portrayed. Do not sample only several locations.
Stage 2	**Outlet Network Development Exploration and Planning**
a.	Collect key information to know the presence of the network of general outlets and alternative outlets for availability, easy access, affordability and acceptance of condoms among beneficiaries. • Identify the existing general outlets • Identify various potential alternative outlets • Identify key person who is influential and is interested in ensuring availability and easy access to condoms and lubricants are maintained in the intervention area • Role of CSO: Collect key information on availability, easy access, affordability and acceptance of condom among beneficiaries Notes:

	• General Outlet:
	  • Places where condoms are usually purchased
	  • Relate to availability
	• Alternative outlet:
	  • Alternative place to get condom
	  • Relate to easy access

b.	Plan and develop alternative outlet network
	• Roles of CSO:
	  • Facilitate a series of informal and formal meetings with relevant parties to plan for networking and to develop operational and management mechanism of the network.
	  • Help develop alternative outlet network
	  • Help facilitate routine meetings of the alternative outlet network so that relevant parties can review the operation of the alternative outlets and discuss current problems.

Stage 3	**Condom Management Structure Development**

a.	Develop Condom Management
	• The role of the manager is clear
	• Create good incentive and performance system
	• Make and sign an MOU:
	  • Roles and responsibilities
	  • Structure and management

b.	Assign the party responsible for condom management
	• To ensure sustainable condom availability at the location, stakeholders at the location level (Location WG) should be in charge of condom management at the location level.
	• If the Location WG is not yet able to take on this responsibility, then the guiding institution/NGO/other institution can mentor or coach until the Location WG can manage independently.
	• The Location WG together with the guiding institution/NGO should appoint a specific team as the party responsible for condom management. In condom management chain, there are at least three parts:
	  1. Procurement – supply – storage
	  2. Distribution – promotion – sales – monitoring
	  3. Record – reporting (money and commodities)

c.	Brief training on condom management for the location working group
	• The training includes the following contents:
	  1. Procurement – supply – storage
	  2. Distribution – promotion – sales – monitoring
	  3. Recording – reporting (money and commodities)

Stage 4	**Procurement and Supply Management**
a.	Determine the sources for condoms and lubricant. • Where to get free condoms, cheap condoms, condoms of certain types. The more alternative sources the better.
b.	Learn the procedures for procurement and ordering. • Each institution and producer has their own procurement and ordering regulations. Early familiarization with these will make the procurement process easier and smoother.
c.	Determine how often procurement and supply should be performed. • Consider average distribution level, sales and utilization including storage capacity and expiry dates of condoms and lubricants. Usually, order should be adapted to "minimum order" requirements of the condom and lubricant producer (if they must be bought).
d.	Determine the person in charge for procurement and supply. • Person in charge for procurement and supply is determined early, as a part of Stage 1 discussion.
Stage 5	**Storage Management**
a.	Determine where the materials will be stored (in an intervention location). • Storage should be as close as possible to the intervention location to make procurement, distribution/sales and monitoring process easier.
b.	Assign person in charge of storage. • Person in charge of storage is determined early, as a part of Stage 1 discussion.

c.	Basic principles of storage.
	• Keep in dry and cool place:
	  ○ Place a board under the commodities to avoid humidity
	  ○ Avoid direct sunlight exposure
	  ○ Avoid storing condoms with chemicals that have sharp odor.
	• There should be only five to six packages in a stack
	• Conduct routine checking to ensure condom condition

Stage 6	**Distribution Management**
a.	Determine the easiest and fastest distribution method. • Make a distribution flowchart from the working group to the user's hand. • Determine the most *efficient* (condoms and lubricants reach users and are affordable) and *effective* (condoms and lubricants arrive and are used immediately) distribution flow • Decide whether the working group will be involved actively or passively in distribution. For example, wait for condom request from the seller, house owner,

	or condom outlet • To save time, it is necessary to consider the minimum number to be distributed.
b.	FIFO Principles • If a large number of condoms is stored, to avoid damage and expiration, distribution should follow the First in – First out (FIFO) principle. The goods that have been in stock longest are first out for distribution.
c.	Assign the person in charge for distribution. • Person in charge for distribution is determined early, as a part of Stage 1 discussion.
Stage 7	**Promotion and Sales Management**
a.	Determine the fastest and cheapest promotion method. • Develop methods for promoting condom use with the beneficiaries and repeat condom use messages regularly. This is necessary because there is a frequent turnover of sex workers.
b.	Continual education to the beneficiaries and other community members (seller, community leaders in the location, security guard, house/entertainment place owners, managers, etc.). • The importance of having condoms available and used should be stressed continually to all members of the community at the intervention location. This is so that all people in the location understand the need for consistent condom use to prevent STIs and HIV.
c.	Develop selling channels • Selling channels should be varied and appropriate for the existing beneficiary segments. In each segment, there should be an outlet. The segments can be identified based on the type of location, type of beneficiary (MSM,MSW, client/s, etc.), certain type of condom for certain segment, etc.
d.	Agree on the highest selling price (HSP) • HSP needs to be agreed on to guarantee the availability of condoms at affordable price. The affordable price will guarantee the flow of money to re-stock the next supply of condoms. • HSP needs to be monitored with a warning mechanism for those who break the HSP rule Sanctions may be applied to a seller who does not adhere to HSP agreement and ruins the existing market.
e.	Manage free condoms in the existing sales mechanism. • Several institutions do not allow their condoms to be sold, e.g. Family Planning Board and Health Office. These condoms cannot be distributed separately from sold condoms. For example, a free condom could be provided with the purchased condom as a bonus.
f.	Assign a person in charge for promotion and sales • Person in charge for promotion and sales is determined early, as a part of Stage 1 discussion.

Stage 8	**Financial Management**
a.	Simple training for sellers • Training includes capital management, rules for good procurement and HSP agreement.
b.	Assign a person in charge of financial management at the working group level. • Person in charge for financial management is determined early, as a part of Stage 1 discussion.
c.	Develop a specific recording mechanism for financial matters, supervision and transparency.
Stage 9	**Recording and Reporting System**
a.	Develop simple recording and reporting forms Recording and reporting forms for seller: - Order form - Commodity receipt form and sales form - Financial form Recording and reporting form for working group: - Commodity procurement and supply form - Commodity stock card for the storage room - Commodity distribution form - Financial form (purchase and income from sales)
b.	Develop a mechanism for reporting and feedback from the condom management team to the Location WG and vice versa.

5. Resources, tools and materials

- List of estimated condom needs; to be confirmed to beneficiaries in every hotspot
- Observation checklist
- Need assessment tools
- List of local condom producers or distributors
- Condom storage room/warehouse
- Forms: condom order, order receipt, stock card, sales, finance

Key Resources

USAID SUM Program CD-ROM

- *Condom Social Marketing Standard Operating Procedure (SOP)*

3.4 Partner Counseling And Referral Services

1. Scope

Regular partner referral involves inviting a regular partner of a beneficiary with a health problem to access available services. Early referral of a regular partner for STI and HIV services can interrupt the chain of transmission.

Partner referral is important to:

- Ensure that effective treatment is given as early as possible.
- Invite the beneficiary to be open to her partner, about their risk behavior and health status.
- Help the beneficiary invite the partner for examination.

From the beneficiary's point of view, there are advantages and disadvantages to disclosing her status to her partner. These need to be considered by the program and the beneficiary.

The benefits of notifying the partner directly include:

- The beneficiary may be the best person to tell her partner an acceptable way
- The partner will appreciate the beneficiary's honesty
- They may adopt prevention behavior sooner if the beneficiary is positive (for HIV or STI)
- The beneficiary and partner can immediately plan safer sex precautions.

The disadvantages of telling the partner directly are:

- If partner hears from other people that the beneficiary is dishonest
- There is a greater chance that transmission may occur if the partner is already positive and the beneficiary is not.

There are some risks if beneficiary discloses her condition to her partner:

- Rejection by the partner
- Loss of emotional support
- Emotional violence
- Physical violence

Methods to avoid the risks:

- Beneficiary talks to the partner directly about his situation
- Ask a third person (close friend) to disclose on behalf of the beneficiary
- Talk to the partner together with the OW
- Ask OW to tell the partner

- OW provides outreach to the partner without disclosing the beneficiary's status
- Ask clinical staff to discuss status with the beneficiary's partner

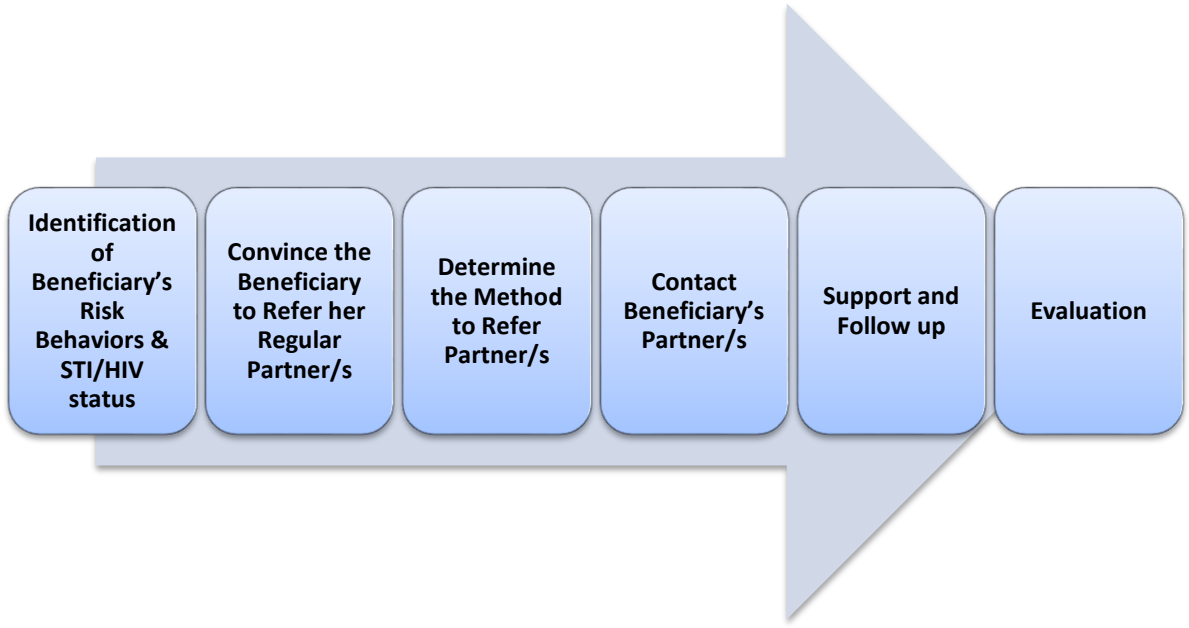
To make the partner referral process successful, the person who refers or the one who accompanies him/her needs must have skills, such as:

- Persuasive communication techniques
- Verbal and non-verbal communication techniques
- Question and answer management techniques
- Decision making/ facilitation techniques
- Conflict management skills

2. Objectives

- To assess a beneficiary's readiness to communicate risk behaviors and/or her disease status to a partner
- To select appropriate methods for disclosing risk behaviors and disease
- To agree on related services and methods of partner referral as soon as possible

3. Stages



Stage 1	Identification of Beneficiary's Risk Behaviors and/or STI and HIV Status

a.	**Identify risk behaviors practiced by the beneficiary** Use various existing activities such as outreach, group discussion, IRA, GRA, VCT counseling, case management and others to understand and summarize various risk behaviors practiced by the beneficiaries. Prioritize behaviors with the highest risk and the ones most frequently practiced. **Notes:** Specifically for IRA and GRA, regular partner referral can be included as one of the beneficiary's risk reduction plan.
b.	**Identify Beneficiary's STI and HIV status** If you are a doctor/paramedic in an STI clinic, STI counselor, VCT counselor and CM, you can probe the beneficiary directly while doing the medical history, examination, counseling or contact the beneficiary. You will need to obtain consent to proceed. Follow related protocol. If you are a Field Coordinator or Outreach Worker, you cannot and are not permitted to probe a beneficiary's disease status directly. You can start the identification process and probe for the disease status only when the beneficiary voluntarily discloses/shares his disease status and you have received permission to probe deeper. Focus the beneficiary identification and STI and HIV status on: • Is the STI and HIV status based on the examination of a medical doctor or is it just based on the beneficiary's perception? • What action has the beneficiary taken about for his STI and HIV condition? • How long has the STI and/or HIV been present?
c.	**Identify beneficiary's regular partner** Through various existing contacts with the beneficiary, determine whether the beneficiary has a regular partner at this moment. Identification: • How many regular partners does the beneficiary have at this moment? • What is the average frequency of sexual contact? • Whether or not the safe sex behaviors are practiced with the regular partner/s? Type, frequency
d.	**Ask about risk behaviors and STI/HIV status that are and may have been experienced by the regular partner according to the beneficiary.** Probe the risk behaviors that may be practiced by a regular partner/s including the risk for injecting drugs. Probe also a regular partner's possible exposure to STI or HIV according to the beneficiary.

	Notes: Even when the beneficiary feels safe, if his regular partner engages in high risk behaviors, the beneficiary can be at risk for STI and/or HIV. Therefore, the behaviors of the partner need to be thoroughly discussed. First ask the beneficiaries. In the next stage (stage 4, contacting beneficiary), the responses should be confirmed with the regular partner.
Stage 2	**Convince the Beneficiary to Refer His Regular Partner/s**
a.	**Explain the need and the benefit of referring regular partner/s.** Explain to the beneficiary that transmission and re-infection to him and his regular partner can be avoided. It is very important to talk this with the regular partner and ask him/her to join the examination, either together (recommended) or separately. **Notes:** This step is only performed if: • The beneficiary has engaged in risk behaviors or suffers from STI and/or HIV • The beneficiary has a regular partner/s • Safe sex practice with regular partner is not consistent
b.	**Assess barriers for referring his regular partner/s.** Probe the beneficiary for barriers and concerns about referring his regular partner/s. Explain the methods and support that will be provided by the FC/OW to deal with the barriers. **Notes:** The barriers may come from: • The beneficiary does not know how to tell his regular partner about STI and/or HIV status referral. She may fear that the partner will feel insulted, betrayed or fearful for his own risk of STI and /or HIV infection. • Beneficiary does not know how to ask the regular partner/s to go to the clinic. • Beneficiary does not know where and how the clinical procedure will be done. • Beneficiary is afraid that the situation will affect their relationship (arguments, separation). • Beneficiary is afraid that she will be threatened or be subjected to physical violence by his partner. • Beneficiary does not have money to pay for the clinical examination • Beneficiary is afraid that others will learn of his and his partner's "secret. "
c.	**Give information on service sites that can be accessed easily.**

	Give complete information on health services that might be accessed easily. This service should be nearby, affordable and friendly. The most important information to be shared includes: • Address and the easiest way to go there • People that can be contacted/seen at the service site • Examination procedure/flow • Cost • Staff (gender, friendliness, ability) • Clinic's environment and surrounding environment
d.	**Use PE/close friend/other role model to convince beneficiary.** Consider asking PE/beneficiary's close friend or other role model to talk with the beneficiary on the need and advantages for referring regular partner/s. If necessary, set a private time for PE and beneficiary to meet without the presence of the FC/OW. **Notes:** If possible, also consider involving the staff from the nearest clinic to convince the beneficiary.
e.	**Postpone and repeat the process of convincing the beneficiary.** In many cases, regular partner referral cannot be achieved in only one discussion with the beneficiary. Several discussions may be needed. Giving the beneficiary to think and to make decision is reasonable. Repeat the process and convince the beneficiary the next opportunity. **Notes:** The delay between postponement and repetition should only be a few days, to avoid transmission.
Stage 3	**Determine the Method to Refer Partner/s**
a.	**Offer the beneficiary choices for referring his regular partner/s.** The method depends entirely on the willingness and ability of the beneficiary. Methods include: • Performed by the beneficiary himself (recommended choice) • Performed by beneficiary's trusted close friend or his partner's close friend • Performed by the FC/OW • Performed by the VCT counselor or CM • Performed by service staff • Combination of 2 or more above options **Notes:**

	Regular partner referral process implies that the referrer should: • Explain the beneficiary's risk behavior situation or STI/HIV status. • Explain the impact of the situation to the partner, especially the ping pong effect. • Explain the need and advantages for examining both parties (beneficiary and the regular partner/s). • Explain the place, procedure, service cost and so on. • Explain support that can be provided by the FC/OW. • Give referral card or accompany the beneficiary to the health service site.
b.	**Explain the benefits and barriers for each choice.** Give every opportunity possible for the beneficiary to ask about existing choices, including the benefits and barriers that may be faced. Encourage dialogue. Beneficiary's questions provide an opportunity for better understanding.
c.	**Agree on the appropriate time and place to contact the regular partner/s.** Arrange the best time and place to contact and talk with the beneficiary's regular partner. Act normally and be relaxed. Prepare yourself for the worst reaction from the regular partner/s (insulted, angry, denial, ask you to leave, etc.) and your response (what to say or do) in such a situation.
Stage 4	**Contact Beneficiary's Regular Partner/s**
a.	**Determine the appropriate method for contacting the regular partner/s.** These methods may include face-to-face meeting (both at the regular partner's place and in other places), telephone or letter. Direct face-to-face contact is highly recommended.
b.	**Perform health education counseling with the regular partner/s.** Try and position yourself as counselor when explaining the above issues so that there is a dialogue, not a monologue. Explain the following issues using simple and respectful language: • Explain the beneficiary's risk behavior situation or STI/HIV status. • Explain the impact of the situation to the partner, especially the ping pong effect. • Explain the need for and advantages of examining both parties (beneficiary and the regular partner/s). • Explain the place, procedure, service cost, etc., that can be accessed by the regular partner. • Explain support that can be provided by the FC/OW in the future.
c.	**Sensitive to confusion and concerns of the regular partner/s.**

	During the explanation and dialogue process, be aware of possible confusion and concerns that may not be expressed verbally by the regular partner. Probe with caution and sensitivity until it is clear. **Notes:** If convincing the regular partner is not working, make another appointment to talk about it later. A second appointment after 3 days can allow the partner to think about the issue and remember it without missing the opportunity.
d.	**Give referral card or accompany the regular partner to the health service site.** If the regular partner has agreed to be examined at the health facility, give a referral card or accompany him/her to go to the clinic.
Stage 5	**Support and Follow Up**
a.	**If the referral is done by other people and not the beneficiary, re-contact the beneficiary and his regular partner/s several days after examination at the clinic.** Try to re-contact the beneficiary 1 or 2 days after examination. Probe the following issues informally: • How are the feelings and attitude of the regular partner after examination? • Was there any fight or violence after the examination? • How did the regular partner respond to the result of the examination? • What's the beneficiary's future plan or regular partner's future plans?
b.	**If the referral is performed by others and not by the beneficiary, offer support.** In every contact with the beneficiary or his regular partner/s, always offer support that can be provided. The types of support that can be offered: • Reminding the beneficiary of the schedule for taking medication or next appointment at the clinic. • Accompany him/her again to the clinic or other referral facilities if needed. • Give condoms and lubricant. • Give necessary additional information. • Offer existing peer support group **Notes:** Specifically for mediation support with fighting between beneficiary and partner/s, an institution should be consulted. Experience shows that it is better that the FC/OW is not involved in this kind of case, unless: • Both beneficiary and his partner want the FC/OW to be involved

	• Listening to the beneficiary or regular partner's story (when they want to talk about it) is requested. • The fighting has already evolved into physical violence
Stage 6	**Activity Monitoring**
a.	**Determine what aspects of this activity will be monitored.** Several general aspects that should be monitored by the program are: • Number of regular partner/s that receive referral services and couple counseling • Number of regular partner/s who access health facility after getting referral and couple counseling services • Number of regular partner/s who are directly referred by the beneficiary and access the health facility • Number of regular partner/s who are not directly referred by the beneficiary (FC, OW, counselor, CM, etc) and access the health facility • Number of regular partner/s who re-visit counselor after the first visit • Regular partner's satisfaction towards the referral and counseling services provided by the NGO. • Regular partner's satisfaction towards existing health facilities • Benefits and barriers of this activity according to the beneficiary and his regular partner.
b.	**Determine the methods to be used in monitoring.** Determine whether monitoring will only analyze program data or whether it will include other additional methods such as: • In-depth interview with the beneficiary and his regular partner • FGD • Exit interview to see regular partner's satisfaction after getting the health service • Survey
c.	**Decide on who will do the monitoring.** In qualitative monitoring, if the monitoring staff is the program implementing staff, several arrangements are needed to avoid bias, such as using program staff from other areas. If possible, use people outside the program to do monitoring.
d.	**Decide on when the monitoring will be done.** The monitoring is better performed regularly. Program data based monitoring should be done every month. Qualitative monitoring can be done once every 6 months or once a year.

4. Resources, tools and materials

Tools and materials needed for this activity are:

- Program data, specifically outreach, IRA, GRA, VCT Counseling, and Case Management data to identify whether the client has regular partners or not
- Medical record for STI and/or HIV (accessible only by medical doctor and clinic staff)
- STI and HCT service delivery in the intervention sites.
- Reporting form for partner counseling and referral services
- BCC materials
- Condom and lubricants
- List of PE accessible and reachable by regular partner
- List of VCT counselor, Case Manager and Clinic staff
- Referral card
- Monitoring tools (questionnaire, FGD guidelines, in-depth interview guidelines, etc.)

Key Resources

USAID SUM Program CD-ROM

- *PCRS Standard Operating Procedure (SOP)*

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4. Access to HIV Services

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4.1 Developing Community-Based Referral Network

1. Scope of HCT, Care, Treatment, and Support

A seamless stream of services is essential for the care of PLHIV to 1) to improve quality of life and 2) to reinforce prevention with people living with HIV. While the PLHIV is still mobile, four main components of support services are available: clinical services, HIV Counseling and Testing, case management and support groups. Case management is critical for coordinating all services to address the needs of PLHIV at various stages of disease progression. Diagram 4 illustrates the relationship of services offered by health care providers at the clinical and community levels.

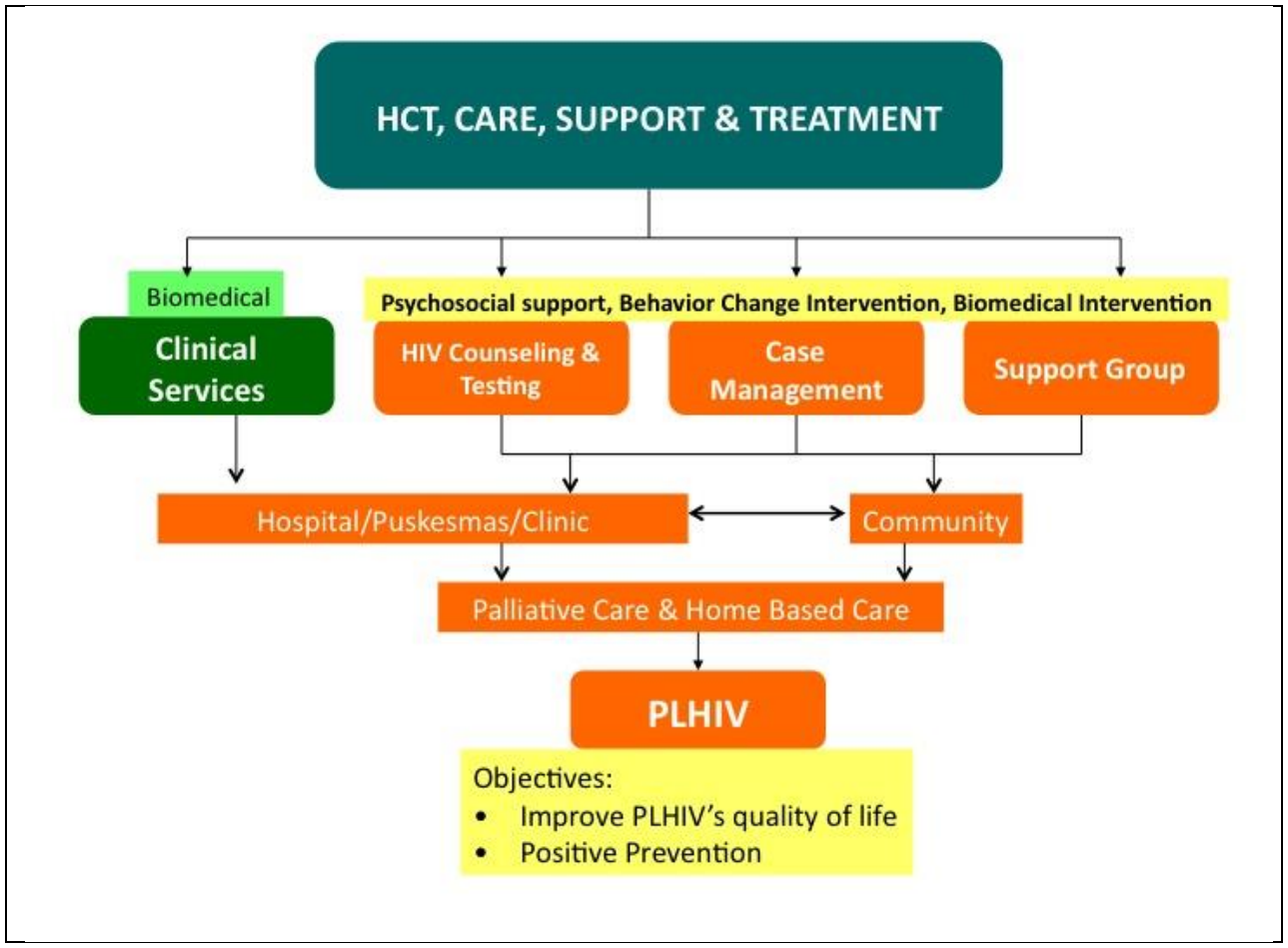


Diagram 4: HIV Counseling and Testing, Care, Support and Treatment

Clinical services are offered at hospitals, *Puskesmas* and clinics. The other components can be provided through these clinical facilities and/or in the community by CSOs. Once a patient is no longer mobile and at the last stages of life, palliative care and home-based services are available to make the patient as comfortable as possible.

Collective efforts from several facilities and organizations, both clinical-based and community-based, are needed to meet the needs of MARPs, including people living with HIV. These efforts also need appropriate policies, supportive social attitudes and a community support system.

As an overall objective, this referral network helps MARPs and those who care for MARPs and family members to:

1) Get the best quality of life possible
2) Reduce the risk of HIV infection or transmission
3) Facilitate active participation in decisions affecting their lives
4) Promote social acceptance and respect towards stigmatized populations, including those living with HIV and those who take care of PLHIV.

MARPs have wide-ranging needs across various life dimensions: physical health, psychosocial welfare, human rights, food source, economic security and spiritual needs. These needs depend on factors such as the age and gender of the person. Moreover, with time and as the disease progresses, the needs also change – of the PLHIV, the people who care for them, and the family.

Care Support and Treatment for Waria Living with HIV

To ensure treatment, care and support for *waria*, the CSO has established linkages with different health centers and hospitals, while religious organizations donate money for their community home-based care activities, and provide coffins when members die. They have *waria* inside selected hospitals and clinics who act as case managers and buddies. These volunteers have good knowledge of HIV. The *waria* prefer one hospital over the others because of the friendliness of the doctor and nurse there. At the beginning they had difficulties because the service providers did not know about *waria*. The hospital asked the *waria* organization what they needed, related to ARV, such as would *waria* prefer to be examined by a male or a female doctor.

The CSO runs two shelters for HIV-positive *waria*, one of which is near to the hospital to make it easier to access health care.

The CSO provides nutrition and welfare help for *waria* living with HIV, who also receive in-kind support from Social Welfare, that includes equipment, wheelchairs and furniture.

CSO buddies are able to provide psychological support to encourage adherence to ART. Many *waria* are afraid of side-effects from the medication, and adherence is affected by emotional and relationship difficulties with boyfriends. Also, some *waria* move around between different cities, and may stop ART or not be able to access it when they move somewhere else. Some stop when they feel healthy.

The CSO *waria* also support each other in positive prevention, preventing HIV transmission within relationships.

It is rare that a CSO can provide all services needed to meet those needs. A well-developed referral network is very important to meet the needs of MARPs and maintain or re-create contact with clients and their families who need continual care and support. Therefore, different facilities are linked together as one coordinated system to ensure a continuum of care services is available and accessible when needed.

However, there is little information available on how to create the network and the standard tools to facilitate an effective network. The standard operation procedures offer guidelines for program managers on how to develop a community-based referral network. **It is assumed that CSOs will facilitate access to clinical services needed by beneficiaries in their locations.** For CSOs who provide built-in specific services such as counseling and testing (HCT) and/or STI services, this document should also be used in combination with other SOPs related to referral network development (i.e., a health facility based referral network).

The referral system also assures that:

- Necessary services are available
- Confidentiality is kept
- Referrals between organizations in the network can be traced
- Referral and referral results are documented
- A feedback loop is established to ensure that services have been provided to the client and needs are met
- Gaps in services can be identified and steps can be taken by the network members to bridge the gap.

Services in a Referral Network

Ideally, the referral network includes organizations in certain geographical area that provide specific services needed by MARPs. Although the list of services is quite long, it is not necessary to wait until all services are available before starting referral network development.

A referral network should be dynamic – services can be added or reduced according to needs of the population, the availability of services in the area, and changes in public health policies and social policies.

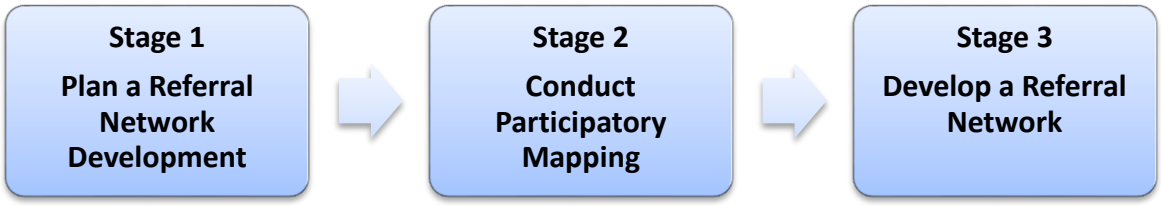
1) Adherence counseling
2) Antiretroviral therapy
3) Child treatment service
4) Clinical services
5) Education/school
6) Family planning
7) Microfinance/financial support
8) HIV counseling and testing
9) Home care
10) Legal, material and mental health support
11) Nutrition counseling
12) Obstetrics and gynecology services
13) Peer counseling
14) Post Exposure Prophylaxis (PEP)
15) Pharmacy
16) PLHIV support
17) PMTCT service
18) Post test group
19) Prevention service
20) Psychosocial and spiritual support
21) Case management and social support service
22) STI and TB services
23) Drug addiction management
24) Support for domestic violence victims
25) Treatment support
26) Teenage support group
27) Positive prevention

The development of a referral network is a very important component of the program. However, the referral network often faces challenges that can reduce or create barriers for the program effectiveness. The categories and standard operating procedure below are aimed at dealing with the most difficult challenges. The categories include: planning, mapping, referral networking and monitoring, and maintaining referral network.

2. Objective

To develop a community-based referral network to facilitate the behavior change needs and health services for MARPs through a high quality, integrated and friendly referral system.

3. Stages



Stage 1	Plan a Referral Network Development
a.	Identify beneficiary population need. Assess beneficiary population specific needs through assessment or formative survey and informal methods. Make sure that relevant representatives of each beneficiary population are covered during this assessment.
b.	Mobilize key stakeholders. Identify and unify various stakeholders in a workshop to start community dialogue, look for inputs on how to build a referral network and create "ownership" for this activity. Other NGOs/CBOs who work with the MARPs in the same area should be invited as collaborative partners because the referral network can also serve their population and also because several populations have overlapping problems, e.g. an MSM who is also an IDU.
c.	Assure active participation of the beneficiary population. Actively involve beneficiary population in the planning process so that their needs and opinions can be identified and used to build the referral network.
d.	Develop a work plan. Make a work plan (with objectives, strategies, activities, partners, budget and schedule). This plan should also include mapping, a training plan, an advocacy and mobilization strategy, routine meetings with the network, development or adaptation of materials/tools, community involvement and a monitoring and evaluation plan (M&E). The M&E plan should include: qualitative and quantitative indicators, instruments and data collecting system, schedule, person in charge, reporting line, etc.
e.	Identify available resources and try to fill the gaps. Identify resources needed to do the program activities (based on the program needs) including resources that can be collected (from other NGOs or CBOs who work with the same population and are interested in developing a referral network) and the existing gaps that need special attention.
Stage 2	**Conduct Participatory Mapping**
a.	Develop and agree on the service selection criteria. Make a list of agreed on criteria to select services. These criteria should include availability, easy access, supportive attitudes from health care workers and counselors, acceptance from the beneficiary population, previous experience serving certain populations, confidentiality, privacy, existing procedures, cost of service provided and other characteristics that are considered relevant for a referral system.
b.	Develop topic guide for service interview and tools to map identified services: A set of

	questions should be developed to assess services based on the criteria developed above. A map can be made to show identified services. Pay attention to the fact that the mapping activity is not aimed at assessing the quality of services provided by the identified and visited organizations. An assessment activity needs a more sophisticated and specific skills.
c.	Identify the team who will do the mapping. This team includes a variety of members and should include NGO/CBO staff, beneficiaries, and health care providers. Avoid bringing too many people from the team when visiting a service.
d.	Conduct mapping. Perform the mapping activity in a short period of time. Do not forget to document the findings during the mapping.
e.	Disseminate findings to the stakeholders. Arrange a workshop with key stakeholders to report findings, distribute the map of the referral network, identify key contact for each needed service and define the roles and responsibilities of each organization in the network.
Stage 3	**Develop a Referral Network**
a.	Make Memorandum of Understanding (MOU) among organizations. This Memorandum of Understanding should include the roles and responsibilities that are identified during the previous step. It is also important to include confidentiality and reciprocal confidentiality between network members in this MOU.
b.	Develop a format, tools and standard operational procedures that will make the referral procedure easier and also will help monitoring the referral network.
c.	Make an appropriate mechanism for referral in order to streamline and document the referral process and follow next steps.
d.	Conduct a sensitization meeting with all organizations/institutions to explain the referral network and identify its members, to approve the MOU and to identify key contacts (focal point) that represent the organization/institution for the referral network.
e.	Train key contacts of related services on procedures for referral system, document utilization, monitoring and also to sensitize them to specific issues in the population served.
Stage 4	**Monitor and Maintain Referral Network**
a.	Mobilize community/group to use and support the network. Conduct intensive community mobilization and activities to increase demand for services (these activities should be connected to behavior change intervention (BCI) for developing materials, promotion materials, service list, etc., that will support the referral network. (See related SOP on Behavior Change Interventions)
b.	Monitor network activities and use the findings to improve the system. The monitoring should include quantitative and qualitative data. Feedback from beneficiaries and service providers of the referral network should also be included.
c.	Arrange periodic meetings with key contacts and beneficiaries in the network. These meetings are the forum for ongoing dialogue, information on how the referral process

	is operating, discussion on challenges and gaps in the service and updates on the network's service list.
d.	Ensure adherence towards program standards. Management staff (internal and/or external) should monitor and ensure adherence towards standards (as stated in the MOU) is systematic and corrective actions are taken if a gap has been identified.
e.	Use M&E for decision-making. Findings from reporting on program activities as well as from all evaluations should be used for adapting program operations.

4. Resources, tools and materials

- Implementing team
- Resource person/trainers
- Need assessment tools
- Memorandum of Understanding example/draft
- Referral tools
- Curriculum and materials of sensitization meeting/training
- Documentation form
- Monitoring and evaluation tools

Key Resources

USAID SUM Program CD-ROM

- *Community-based Referral System SOP*
- *BCI Training Module: Outreach workers/field workers responsibilities on building networks for referral services*

4.2 STI Screening and Treatment

Sexually Transmitted Infections (STI) are acquired during sex with an infected partner. STI prevalence is high among MSM. MSM have a markedly greater risk of being infected with HIV compared with the general population of men. Baral et al. (2007) estimated the magnitude of elevated risk to be approximately nine-fold. CSOs have an important role to play in establishing community-based service networks for MSM referral, and in facilitating delivery of direct health services.

Linking MSM to STI Services

One CSO has a strategy of developing a relationship with a local *Puskesmas* and then structuring their services to support taking clients to the clinic, and getting clinic services sensitive, appropriate and effective so that clients can return regularly. Building an effective pathway to services involves a step-by-step process that helps to engage MSM and encourage health-seeking behavior. The CBO staff first go and introduce themselves to the *Puskesmas*. Then the outreach worker encourages the clients to go to the clinic for services. For the first visit, MSM are worried about the services and things like confidentiality, and so the MSM go to the clinic along with a CBO outreach worker. After the first visit the MSM are confident enough to return to the clinic by themselves.

The CBO organizes coordination meetings every three months with the *Puskesmas* staff, to look at the results of the clinical services and evaluate the project. During these meetings they are able to raise and solve problems between the MSM and the clinic. For example, at first the MSM clinics were in the evenings, but the clinic hours were changed to afternoon, which the MSM clients preferred. Outreach staff are able to teach the Puskesmas staff about the different types of MSM, and help change the staff's mindset. Once they are familiar with the MSM population, they are better able to provide services, including general health as well as STI and HCT.

1. Importance of MSM Access to STI Services

Failure to detect and treat STI early on may result in serious health complications. For men, STI can cause reproductive health problems, e.g. infertility, impotence, cancer and other health problems.

STI services are also an entry point for HIV prevention and care. Routine examinations can manage STI among MSM and are essential for key populations who engage in high-risk behaviors.

2. Objectives of STI services

- To diagnose and treat STI
- To prevent STI transmission to sex partners
- To strengthen safer sex practices
- To prevent infertility caused by STI

3. Types of STI services available

- Routine Screening: Regular STI examinations whether with or without symptoms. Testing is recommended at the minimum of two times per year. STI screening should not be delayed since condom use is low.

- Periodic Presumptive Treatment: In Indonesia, an antibiotic treatment is given for presumed infections (gonorrhea and chlamydia) to individuals or a group of people at high risk of infection, including MSM, at regular intervals (every three months). The purpose is to decrease the incidence of STI infections in a short period of time. To be effective, treatment must be accompanied by consistent condom use. PPT for MSM is still under discussion.

- Symptomatic STI treatment: MSM who experience STI symptoms should present themselves immediately to health services for diagnosis and treatment.

4. MoH Guideline – Principles of STI Services for MSM

- Receive routine screening whether or not symptoms are present.
- Take a complete course of medication for STI.
- Bring partner for testing.
- Return to health facility for follow up to ensure STI is cured.
- Always use condoms during sexual contact.

5. Education and promotion of services (demand generation)

Key messages for STI prevention:

- STI are caused by viruses, bacteria, or parasites:
  - Viruses: herpes simplex virus, human papilloma virus
  - Bacteria: gonorrhea, chlamydia, syphilis, lymphogranuloma venereum
  - Parasites: *Trychomonas vaginalis*, *Ptyrus pubis*

- Common symptoms noticed by the individual:
  - Urethral discharge. **Most often men are symptomatic.**
  - Painful urination
  - Itchiness around the genitals

CSO Support for Clinical Services

An important element of generating and sustaining demand for public health services among MSM is supporting the clinical teams at these sites in an ongoing manner.
One CSO Program Director explained that *Puskesmas* and public hospitals in some areas have monthly caseload targets they need to achieve to release the next month of funding. This fact makes them highly motivated to reach most-at-risk populations for HIV and provides an opportunity to develop relationships. However, establishing supportive relationships with clinical staff was difficult in the beginning. Many clinic staff had very little experience with MSM and expressed views that were homophobic and lacked knowledge of issues affecting them.

The CSO's response to these difficulties was persistence. They continued to attend clinics and offered orientations to staff to provide minimum-levels of knowledge about MSM and their behavior. At that time it was common for clinical staff to ask questions like "When are you going to get married?" and "When will you become normal?" The orientation sessions they ran in these clinics helped to establish relationships with staff and the CSO followed-up with the staff to help answer questions and concerns that emerged in their clinical practice.

- Warts in the genital or anal area

6. Enable MSM to access STI services

The CSO can strengthen routine screening for MSM for early detection of STI and refer MSM to the nearest health facility (*Puskesmas*/STI clinic) if symptoms are present. CSO can arrange mobile health clinic schedule at hotspot or DIC. CSO can also arrange that several MSM as a group from hotspot present themselves at the clinic for routine screening.

7. How are CSOs able to establish Referral Networks for STI services?

1) Find out about referral networks in the community.
2) Identify service providers to be included in the network.
3) Make a referral directory.
4) Make arrangement for referrals (MOU) among service providers.
5) Establish a reporting and feedback system.
6) Maintain relationships to strengthen the referral network.
7) Identify a contact person at each facility.
8) Know the schedule for services, day and hours.
9) Understand steps used at the facility for accessing care and treatment services.

Helping a Health Provider to Understand about MSM

One MSM worker has developed a relationship with a *Puskesmas* doctor, which provides an example of how CSO workers can assist and advise clinical staff in a way that improves their clinical services with MSM.
The CSO approached the *Puskesmas* initially so they could send MSM to the clinic for STI services. At first the doctor at the *Puskesmas* "did not feel comfortable with MSM" and did not want to assist them. The doctor felt that these men were "sissies" (effeminate) and not "real men". The MSM worker began by providing the doctor with an ongoing relationship so he could share his feelings and experiences openly. The MSM worker explained that there are different types of MSM. Some are effeminate and some are not, some engage in receptive anal sex while others are insertive, and others do not like anal sex at all. All of them, he explained to the doctor, have a right to services through the public health system. At the same time, the CSO kept referring MSM to the clinic so the staff were getting more and more exposure to MSM and their clinical presentations. The MSM worker helped the doctor better understand the behaviors and life issues of MSM and the doctor consulted him about what sorts of questions he should ask MSM patients to identify their risk for particular STIs. He encouraged the doctor to avoid making judgments about his patients and explained that MSM would not return if they felt judged or ridiculed. He taught the doctor the language that some MSM use when talking about sex: "*tempong*" for anal sex, "*ngsesong*" for oral sex and "*dendong*" when a male dresses as a woman.
As a result of this ongoing relationship, the doctor is now very experienced and an effective medical practitioner for MSM and mentors other staff in the *Puskesmas* to help them develop their skills and sensitivity to MSM in the clinic setting.

4.3 HIV Counseling and Testing (HCT)

4.3.1 Why is HIV Counseling and Testing Urgent?

It is estimated that 70-80 percent of global HIV transmission occurs between infected persons and their partners through unprotected sexual intercourse. Men who have sex with men (MSM) have become infected at high rates in Indonesia. HIV Counseling and Testing (HCT) is the key entry point to HIV prevention, care, treatment, and support services for MSM.

4.3.2 Types of HIV Counseling and Testing Services Available

HCT can be initiated by the MSM or recommended by the counselor or care provider as part of a package of services provided to all patients in the health facility or its outreach services. Clients have the right to **opt-in** and receive HIV testing, or ***opt-out*** and decline HIV testing.

There are two approaches to HCT: client-initiated counseling and testing or Voluntary Counseling and Testing (CICT/VCT); and Provider-initiated Testing and Counseling (PITC)

1) Client-initiated Counseling and Testing or Voluntary Counseling and Testing (CICT/VCT)

MSM voluntarily seek to know their HIV status through CICT/VCT. The dialogue between a counselor and client, couple or a small group of clients enables clients to: receive accurate information on HIV testing and make informed decisions on whether to be tested for HIV; to understand test results; and make future plans.

Counselors must be sensitive to the issues faced by MSM, for example, if they experience fear related to their sexuality. MSM often do not disclose their sexual orientation due to stigma and discrimination that they may face after disclosure, and are reluctant to seek needed health services. So counselors must draw out information regarding sexual practices in order to determine their level of STI and HIV risk.

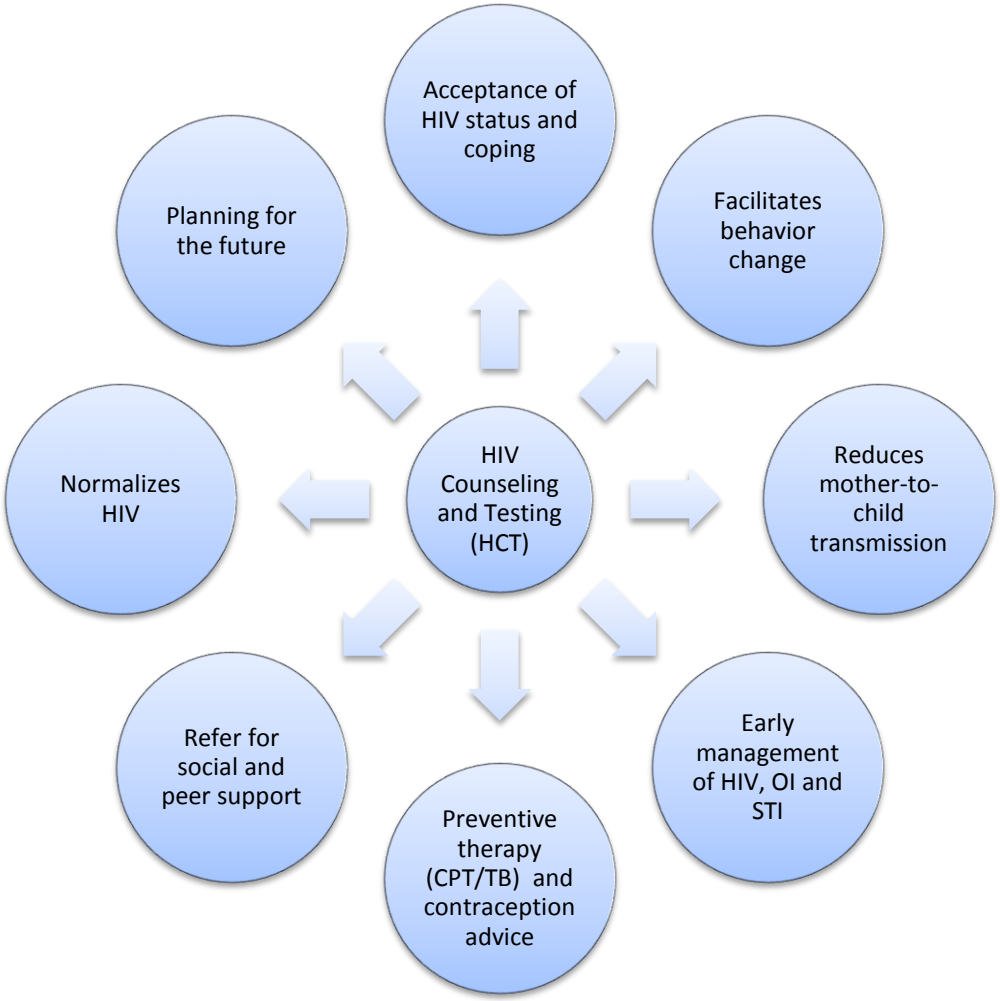
CT Main Components

1. Client registration
2. Pre-test counseling
3. Consent for HIV testing
4. HIV testing
5. Test results provided
6. Post-test counseling
7. Follow-up counseling

CT Strategies

- Outreach activities to promote VCT services.
- VCT centers should be user-friendly and comfortable for MSM, and operate at hours convenient to their work day.
- Encourage establishment owners and clients of MSW to receive VCT services.

HCT as an entry point for HIV prevention, care, support and treatment



A CSO's Role in Encouraging Waria to Test for HIV and STIs

The *waria*-led CSO has established a unique relationship with an NGO sexual health clinic providing services to MSM and transgender people. The clinic works in partnership with a range of community-based agencies to generate demand for its services. The CSO's encouragement of *waria* to test for HIV and STIs is largely realized through its outreach services whereby field workers generate interest among ten *waria* at a local site and then accompany them as a group to the clinic. Field workers explain that attending this clinic is easier than attending other clinics because *waria* are employed there as administrators and counselors. "They [the *waria*] feel safe to come because *waria* are there," explains the CSO's VCT Counselor. "But we cannot say 'let's all go for VCT' because that gets no result. *Waria* are very afraid of needles and of health services generally so we say instead "let's go and check our health" and this is more likely to be accepted."

At the clinic the field worker helps each *waria* to register, then a doctor undertakes pre-test counseling and a health check; finally, post-test counseling is provided by a *waria* counselor who provides the test result. Those who test HIV positive are immediately referred to a CSO case manager and those who test HIV negative are referred to *the* CSO's community groups and other services and are met again in their local area by a field worker. A source of sadness for the CSO staff is the number of *waria* who are testing HIV positive "and [already with] stage three or four [HIV disease]. The problem is there is no willingness to go for prevention and to the doctor… it is too late and many have already died." A report by USAID concluded that *waria* resist attending services because of misunderstanding of the benefits of VCT and ARV treatment, fear of discrimination if diagnosed HIV positive and the lack of *waria*-friendly clinical services near where *waria* work and live (USAID 2005).

The resistance to health checking among *waria* has resulted in the clinic establishing a mobile HIV and STI service that operates in all of the five districts of Jakarta once per month respectively. The clinic and CSO work together through these two service options to supply and generate demand for HIV and STI screening among *waria* across Jakarta.

In order to maximize the options available to Jakarta's *waria* networks, the CSO has also developed relationships with *Puskesmas* that provide VCT and STI diagnosis and treatment. In most cases, these relationships are not as innovative or effective as the partnership the CSO has established with the NGO clinic. But, "little by little *waria* are interested in accessing the *Puskesmas*" and the CSO works with the district and Provincial AIDS Commissions in the city to improve relationships with teams at these sites.

1a CITC/VCT Main Components

1. Client registration

Clients are registered and given codes to maintain confidentiality.

2. Pre-test counseling

Pre-test counseling is provided to individuals and couples to ensure that they have relevant and accurate knowledge to help them decide whether to be tested for HIV. Clients also explore their risk of HIV and learn about appropriate prevention strategies. The following information is included in HCT:

- Information about HIV and positive prevention
- Information on the "window period" when the test may not detect HIV antibody
- Benefits of testing
- Coping with the diagnosis
- Discussing decisions that need to be made
- Referring clients to appropriate treatment and care services, such as case management, ART and PMTCT

3. Consent for HIV testing

Counseling and testing must be voluntary. People should be encouraged to seek, and not be coerced, to be tested. Consent can be obtained before the test in written or verbal form.

- Ensure clients adequately understand benefits, implications, and consequences of HIV testing.
- Clients have to right to withdraw consent at any time, even after blood has been drawn for HIV testing.
- Recognize that the validity of giving consent to HIV testing may be diminished by the aged and those with mental impairment.

4. Provide HIV test results

Test results should never be issued in a public area, but in private, and in a face-to face session with the client or couple. The pretest counselor should be the same person who gives the results to the client.

5. Post-test counseling

All clients undergoing HIV testing should be provided with post-test counseling in person. In situations where the counselor does not perform the test, results should be sent to the

requesting counselor or service provider. Counselors at all HCT sites should follow the standardized protocol for providing post-test counseling. The form of the post-test counseling session depends on the test result.

- For MSM with a **positive test result**, sessions will focus on providing information on coping mechanisms to the MSM and referring him to case management to access support, care, and treatment. Every opportunity should be given to the MSM to express his feelings about the result and other related personal issues he faces. The post-test counseling session should include the development of a risk-reduction plan specific to his personal life situation and positive prevention.

- For an MSM with a **negative test result**, sessions should encourage those who have had recent risk behavior or known exposure to return for confirmation after three months, since they may now be in the window period. Moreover, encourage clients in the window period to practice risk-reduction behaviors. Those who are HIV-negative and have no recent possible exposure do not need *confirmatory testing.*

For **both HIV-positives and HIV-negatives:**

- Encourage partner notification. Learning test results together is the best way.
- Provide education and counseling on sexual health.
- Offer condom education. Demonstrate how to use condoms and provide condoms for those who are willing to use them. Do not coerce unwilling clients.
- Provide additional supportive and informational counseling.

6. Follow-up counseling

Counselors should review what was discussed during post-counseling and identify any information that should be discussed in follow up sessions. Emphasis should be placed on prevention of further transmission, involvement of partners and family members, coping mechanisms, and identifying and referral to available support services (case management) and resources.

<u>1b. VCT Service Delivery</u>

1. Integrated services

Integrated services are provided by the CSO, primary health center, hospital, and other community health settings that are designated as VCT units that integrate TB, STI, PMTCT, and ART drug management.

2. Stand-alone services

Stand-alone counseling and testing services are mostly provided at sites outside health facilities. Sometimes VCT is linked with care, treatment and support services.

3. Mobile outreach services

Mobile outreach VCT services should be considered for special populations, such as people in remote rural areas, FSW, IDU, MSM, the military and prisoners. These services can be integrated with existing primary health care services and should be linked to the nearest care and support organization with an established referral system.

4. Objectives

The CSO will be able to:

- Promote and sustain behavior change in HCT services.
- Link HCT with other interventions, including prevention of mother-to-child transmission (PMTCT), STI services, and prevention and treatment of tuberculosis (TB) and other opportunistic infections (OI).
- Facilitate early referral to comprehensive clinical, psychosocial, case management and community-based prevention, and care and support services, including access to antiretroviral therapy (ART).

1c. MoH Guideline – Principles of VCT Services

The Indonesia Ministry of Health (MoH) has developed guidelines for VCT services. Voluntary HIV Counseling and Testing is regarded as a crucial component of a comprehensive response to HIV for vulnerable and high-risk groups (FSW, IDU, and MSM).

Voluntary Counseling and Testing

Voluntary Counseling and Testing
- VCT services should be completely voluntary and requested by the client
- Informed consent is always required.
- Confidentiality must always be maintained.

Voluntary **Counseling** and Testing
- Pre-test and post-test counseling is always required.
- Counseling should emphasize behavior change and prevention.
- Couple counseling is recommended.
- Counselors should refer clients to other appropriate services if needed.

Voluntary Counseling and **Testing**
- Simple, rapid, whole blood tests for same-day or same-hour results are recommended.
- Serial testing is the minimum standard: three different types of rapid test.
- Testing should be done by a laboratory technician if possible.

Who should **provide** VCT?
- All VCT providers must be trained in VCT counseling and service delivery.
- VCT counselors should be carefully selected and their duties adjusted so they can concentrate on VCT services.

Who should **receive** VCT?
- Anyone serious about behavior change should receive counseling.
- Those with more than one sexual partner should seek counseling.
- Those diagnosed with a sexually transmitted disease or tuberculosis need counseling.
- Couples before starting a relationship, before marriage, for pregnancy planning should seek counseling.

In addition to the above, the following should be integrated into the services:

- Test results, positive or negative, should be related to clients *in person*, and must be accompanied with post-test counseling. No results will be provided in certificate form.
- Client confidentiality will be maintained at all times. Results can be shared with other persons only at the clients' request or by those involved in clinical management of clients.

1d. Registration of VCT sites

Government health facilities providing VCT must be authorized by the appropriate government units – Ministry of Health, regional health department, or district health office. Private and CSO sites must register with the authorities to assure that standards are met and appropriate assistance is given when needed.

1e. How can CSOs support individuals with VCT services?

Ways CSOs can support individuals:

- Follow-up VCT counselors can ensure access to and refer clients for the necessary care and support services (see adjacent text box).
- Involve families, case manager/social workers, community support groups, and volunteers in the care of people living with HIV

Space For VCT Services

People who wish to know their serostatus have concerns about confidentiality and privacy. There is also evidence that assurance of confidentiality and trust facilitates disclosure of risk behaviors. It is imperative that the VCT rooms, reception area and laboratory are private and are attractive and comfortable to FSW.

See adjacent text box for the minimum recommended space for a site that sees 8-10 clients per day.

Minimum Space for VCT Services

- One counseling room
- Reception and administrator area
- One waiting room
- One laboratory space
- One patient screening room (optional) for collecting fees, collecting data, and so forth

Basic Services for Referral

1) CSO or primary health facilities or for HIV including treatment for opportunistic infections.
2) Case management program and psychosocial services.
3) Peer support groups and post-test clubs.
4) Income-generating groups or micro-credit organizations.
5) Orphan or vulnerable child support services, including assistance with school fees.
6) Home-based care programs, including food distribution to vulnerable households
7) Sexual and reproductive health services, including STI diagnosis, treatment and contraceptive advice.
8) PMTCT services.
9) Suppliers of condoms and injecting equipment.
10) Drug substitution treatment services for FSW injecting drug users.

MoH Checklist
VCT Equipment and Supplies

Counseling Room
- Three chairs (counselor, client, and partner)
- Desk and chair
- Two steel filing cabinets
- Storage space for blood drawing equipment (e.g., syringes, needles) and medical consumables
- Disposal container for sharp objects
- AC or Fan (optional)
- VCT Toolkit
- Glass, water, tissues and IEC Material (e.g., condom)

Reception/Administrator Room
- Cash box
- Desk and chair
- Two upright chairs
- Steel filing cabinet
- Office supplies
- Telefax machine
- Computer for data entry (optional)

Waiting Area
- Television and Radio (optional)
- Two benches and enough chairs for seating
- Storage space for communication materials
- Open display for educational materials

Laboratory
- Working counter
- Refrigerator
- Desk and chair
- Sink with elbow taps
- Running water (hot and cold)
- Soap and towel
- Medical consumables, including gloves, needles and syringes or lancets, swabs, spirits, etc.
- Lockable storage for test kits
- Standard contaminated waste disposal facilities
- Adequate light source and ventilation

2). Provider-initiated Testing and Counseling in Health Facilities (PITC)

Provider-initiated HIV Testing and Counseling presents an opportunity to ensure that HIV is more systematically diagnosed in health care facilities in order to facilitate patient access to needed HIV prevention, care, support and treatment services.
For FSW presenting *with symptoms or signs of illness possibly attributable to HIV,* the health care provider is responsible for recommending HIV testing and counseling as part of routine clinical management. Providers may also recommend HIV testing and counseling to patients who do not exhibit obvious HIV-related symptoms and signs but who may have an STI.

Why is HIV Counseling and Testing Urgent? – Provider-Initiated Testing and Counseling in Health Facilities (PITC)

It is estimated that 70-80 percent of global HIV transmission occurs between infected persons and their partners through unprotected sexual intercourse. MSM have become infected at high rates in Indonesia. HIV Counseling and Testing (HCT) is the key entry point to HIV prevention, care, treatment, and support services for MSM.

Provider-Initiated Testing and Counseling in Health Facilities (PITC)

Different Approaches:

1. The doctor and counselor work together as one team. The doctor suggests the HIV test and the counselor provides one-on-one or group pre-test and post-test counseling.

2. The doctor alone suggests the HIV test, provides brief information, and also gives the result.

3. The doctor suggests the HIV test, provides brief information and hands over to the counselor for giving results.

Types of HIV Counseling and Testing Services Available

HCT can be initiated by the MSM or recommended by the counselor or care provider as part of a package of services provided to all patients in the health facility or its outreach services. Clients have the right to **opt-in** and receive HIV testing, or ***opt-out*** and decline HIV testing.

There are two approaches to HCT: client-initiated counseling and testing or Voluntary Counseling and Testing (CICT/VCT); and Provider-initiated Testing and Counseling (PITC)

Strategies PITC for MSM

Please note that CSOs encourage MSM to attend routine STI screening. During the examination, the provider has to initiate PITC.

1. STI services
HIV is primarily transmitted through sex, and the presence of a sexually transmitted infection (STI) can increase the risk of HIV acquisition or transmission. STI clinics are an important venue for increasing knowledge of HIV status among both men and women who are sexually active and increasing access to HIV prevention, treatment, and care.

2. Tuberculosis clinics
In generalized epidemics, hospital medical wards usually have a high concentration of patients with HIV who would benefit from treatment and care. Because not everyone with severe HIV-associated immunodeficiency has obvious clinical symptoms or signs of disease, HIV testing and counseling should be recommended to all patients including MSM admitted to hospitals and other inpatient facilities in generalized epidemic settings. This includes patients suspected of having, diagnosed with or being treated for tuberculosis. Although outpatients are generally less ill than inpatients, HIV testing and counseling should also be recommended to all persons attending medical outpatient facilities in generalized epidemic settings.

4.3.3 Education and Promotion of HCT Services (demand generation)

Promotion strategies are intended to increase access and uptake of HCT and/or reduce existing barriers to access. Possible strategies:

VCT

1) Mobile VCT services at convenient places, e.g., drop-in centers, bars, cafés, establishments, etc.
2) Mobile VCT at events, festivals, special events, etc.
3) Enhanced peer promotion among MARPs using national and local networks, including via internet social networking.

4) Online publication of information for MSM with clear explanations of mobile VCT procedures and lists of services and providers that are "MARP-friendly."
5) General public service information campaigns to encourage people to learn their HIV status.
   Formalizing "connections" between public health facilities and community-based organizations to provide outreach and referral services

PITC

1) PITC should be available in in-patient and out-patient services at hospitals and out-patient clinics for patients with symptoms and signs.
2) PITC should be provides for all TB patients seeking treatment at *Puskesmas*, hospitals and lung and TB clinics.
3) It should be provided for all persons seeking STI treatment at health facilities.
4) PITC shall be promoted as part of standard clinical management and care in all health facilities.

4.3.4 Steps CSOs can take to establish referral networks to HCT services

The referral network is part of the backbone for HCT services. Provision of effective and quality counseling and testing services requires identification and development of linkages between care and support programs, and formalizing referral networks. A map and regularly updated referral directory of community and institutional care and support service providers and community organizations that offer services should be available for all health care providers and for people living with HIV. The directory should include the range of services offered, addresses, and contact persons and relevant information.

Two-way referral system from community to social or health care services and back to the community enhances flow in the referral process.

HCT Referral Network

Planning and Management Steps:

- Find out about referral services in your district.
- Identify service providers to include in the referral network.
- Make a Referral Directory.
- Make arrangements for referrals.
- Establish a reporting and feedback system.
- Maintain relationships to strengthen the referral network.

4.3.5 Resources, tools and materials

Resources

- **Staff**

Sites providing HCT services should ensure adequate staffing in accordance with demand for services and

resources available. Counselors, doctor, case manager, and laboratory technicians (where applicable) are expected to work as one team responsible for any activity or issues related to HCT. The staff must have received training as required by the MoH.

Teams should:

- Establish site level management for operations and technical staff
- Adhere to the HCT procedures and protocol developed by the MoH
- Ensure that HIV test results are given in person
- Ensure clients receive appropriate HCT services and referral
- Monitor day to day site activities
- Ensure adequate supplies are on hand and request supplies in time to prevent stock-outs
- Identify agendas for operational research

Minimum Staff requirements:

- One **counselor, doctor or paramedic** for CICT/VCT or for PITC for 8-10 clients per day. Additional counselors are required for sites with more than 10 clients per day. One **laboratory technician** should be dedicated to perform testing but if he/she is not available, a nurse can draw blood and the blood should be sent to the authorized laboratory.

- A **program coordinator** (supervisor) is required for free-standing sites.

In order to ensure optimal use of limited resources and maximum impact of services, coordination should take place at the national level. Key elements of HCT coordination may include the following:

- **Training HCT personnel**

Standard comprehensive training should be given to counseling and testing providers. See box above for requirements in training curriculum for all categories of counselors.

<u>Training Curriculum</u>
All Categories of Counselors

Should include:

- Overview of HIV/AIDS and comprehensive prevention, care and treatment information
- Principles of HIV counseling and testing
- Techniques and implementation of rapid HIV testing
- On-going counseling
- Program management/coordination and supervision, referrals, monitoring and evaluation related activities, such as record keeping and reporting formats
- Provider-initiated approach for health professionals

- **Supplies**

The quantity of supplies depends on the estimated volume of clients expected and the testing protocols adopted. An efficient system for managing stock is needed that includes space to store items properly, staff that follow guidelines for proper storage of health commodities, and a procedure for ordering and receiving supplies on time.

Core supplies include:

- HIV test kits
- Gloves and all other medical supplies, including those for universal precautions.
- Sharp disposal containers
- Disinfectant.

If additional medical testing is envisaged as part of the VCT service in stand-alone clinics, other supplies will be necessary, e.g., TB screening, STI screening.

- **Materials**

To offer high-quality HCT services at any site, HCT program planners should be familiar with and/or prepare to develop or address the following:

1) National policy issues and plans regarding CICT/VCT-PITC services
2) Guides for site selection, development, support and maintenance processes
3) Protocols for counseling and testing
4) Training materials and tools
5) Documents for mapping community support resources for case management system
6) Promotion and advocacy, including the need for communication materials
7) Monitoring and evaluation, including quality assurance measures
8) VCT Toolkit
9) Data collection and reporting materials
10) Data flow system of HCT program and referral documents

- **Equipment**

See the earlier text box for the MoH recommended Checklist for HCT Equipment and Supplies.

4.3.6 Monitoring and Evaluation

Monitoring and evaluation is a key component to create and sustain demand for counseling and testing services. All HCT sites collect data related to service uptake using recordkeeping and reporting formats approved by the MoH.

The collected data are analyzed and interpreted to help in planning and decision-making. A monthly or quarterly report should be written and transmitted to appropriate authorities. [For more details, see sections in this manual on QA/QI and M&E.]

1. Evaluating the HCT program

Evaluation of an HCT program assesses whether the program is effective in achieving its objectives – WHAT and HOW much change occurred at beneficiary level.

Monitoring Indicators

Voluntary Counseling and Testing Indicators

- Client source of information about VCT services
- Client demographics (individual and couples)
- Number of clients who come to the VCT site for counseling or testing
- Client informed consent and counseling offered before a client takes an HIV test
- Number of clients who receive prevention counseling
- Number of clients tested for HIV
- Number of clients declining to take the HIV test
- Number of clients who receive their HIV results the same day
- Number of client seeking VCT services as a couple
- Number of clients previously tested (as individuals or as a couple; new partner or old partner)
- Non-return rates (if clients do not return to learn their HIV results)
- Condom distribution (number of clients offered condoms, number of clients accepting or declining them).
- Number of clients who receive referrals and follow up
- Established system for quality control and quality assurance for HIV counseling if CSO provides services (When HIV testing occurs, the CSO gathers information on whether or not the client feels services were "friendly.")

Provider-initiated Testing and Counseling Indicators

- Number of patients tested for HIV in TB, STI, and other clinics
- Number that received results
- Number with HIV-positive result

2. Process evaluation: QA/QI

Process evaluation uses information such as service delivery data, supervisory reports, client satisfaction, counselors' views, and quality assurance data to determine if services are delivered according to plan. Adjustments can be made to provide ongoing quality improvement of program activities.

3. Monitoring indicators

The MoH has established a set of performance quality indicators by type of service site, specifically for VCT services in Indonesia (see text box).

Key Resources

USAID SUM Program CD-ROM

- *Monitoring Data Collection Tools, Roles, Responsibilities and Frequencies*

4.4 Care

4.4.1 Prevention Case Management

Case Management (CM) includes prevention with people who are HIV positive and people who are HIV negative.

1. Scope: Why should MSM access CM services?

MSM face stigma and discrimination in their environments. Case management is a mechanism for coordinating and managing an array of services for individuals and/or families. HIV case management services are client driven. The primary goal of the service is to increase access to and maintenance of primary medical and supportive services so health outcomes improve and client self-sufficiency increases.

The case manager acts as a broker on behalf of HIV-positive MSM for needed services. Even brief interventions by case managers have been associated with significantly higher rates of linkages to HIV care services and reported significant decreases in risk transmission behaviors, including insertive anal intercourse by MSM, and needle sharing by IDU. The case manager also promotes adherence to treatment and helps MSM face fears, stigma and discrimination.

2. Objectives

The overarching goal of case management is to facilitate client autonomy to the point where they can obtain needed services on their own. While there are exceptions, in general case managers do not provide direct services such as mental health therapy, substance abuse treatment, or legal assistance, but refer clients to trained providers.

CM objectives:

- Personalized assistance for clients with multiple and complex needs related to HIV
- Plan and provide individual, multiple series of counseling sessions on HIV risk-reduction that support MSM to start and maintain risk reduction behaviors and prevent secondary acquisition of HIV
- Assess client risk of contracting other STI and ensure timely screening and treatment
- Facilitate referral services for client medical and psychosocial needs

Responsibilities of the case manager:

1) Do intake and assessment of MSM needs and resources in the setting.
2) Develop and implement individual service plans (ISP).
3) Intervene on behalf of the client or family when necessary.

4) Refer to and coordinate for needed services.
5) Conduct regular reassessment of client health condition and needs (minimum of every six months).

The CM receives clients from 1) outreach, 2) VCT counselor, and 3) doctor referrals from hospitals.

3. Services components

Eligibility and intake

Information from the doctor is used by the CM to determine client eligibility to begin ART. Intake includes collecting demographic data, emergency contact information, and next of kin information besides eligibility documentation. Case managers also determine whether or not clients require crisis intervention and ensure client confidentiality throughout intake and service delivery. Client information will only be released with the client's consent (release form). Case managers assist clients to make appointments with medical providers as early as possible following the initial intake process.

Comprehensive Assessment and Reassessment

The case manager evaluates whether or not the client has the social network and financial resources to access medical care, receive psychosocial support, and care giving in the home. The assessment includes:

- Client current capacity to meet needs
- Extent to which other agencies are involved in client care
- Services that require case management assistance

Reassessments are conducted at minimum once per year, when there are significant changes in a client's condition or status, or when the client has left and re-entered the case management program. Information from the reassessment is used to develop or update the client's Individual Service Plan (ISP).

Assessments and reassessments require the following documentation to be kept on file in the client records (see table below):

- Date of assessment or reassessment
- Signature and title of case manager completing the assessment
- Assess client's level of acuity (acceptance of HIV status, acceptance and readiness for services)

Individual Service Plan (ISP)

An Individual Service Plan is developed to address client needs. An ISP is developed for each client within two weeks of the assessment or reassessment, and is updated on an ongoing basis, not less than once every six months. ISP includes:

- Name, date and signature of the client
- Name, date and signature of case manager
- Date and signature of the client on subsequent updates
- Client goals, desired outcomes, steps for the client, case manager and other providers, and the timeframe for accomplishing steps and goals

Assessment Areas

1) Medical health care status and adherence issues.
2) Mental health status issues and client social support system
3) The level of acceptance from the client's neighborhood and neighborhood groups
4) Client's sexual relationship history (number of partners in last six months)
5) Risk behaviors and HIV prevention issues
6) Substance use history and treatment
7) Housing and living situation, nutrition/food security
8) Education, employment and financial resources
9) Family and dependent care issues
10) Stigma and discrimination and other domestic violence issues
11) Religious and spiritual support
12) Legal issues including incarceration history

Implementation of ISP, Monitoring and Follow-up

The case manager continues ongoing contact with the client and monitors the effectiveness of meeting client needs or if any changes or updates should be made to the ISP. Case managers also:

- Confirm referrals, service acquisition, service delivery and adherence to treatments.
- Act as an advocate for clients when needed. For example, help resolve any barriers to care or treatment adherence.
- Empower clients to use independent living skills and strategies.
- Maintain client contact, with at minimum one face-to-face meeting once every three months, or phone contact every month.
- Actively follow up with clients who have missed a case management appointment by the end of the next business day. In the event that follow-up activities are not appropriate or cannot be conducted within the prescribed time period, case managers will document reason(s) for the delay.
- Date and sign progress notes that detail activities and file notes in the client's chart.

4. Types of CM Services Available

Health setting

Case management facilitates continuous medical and support care for PLHIV linking basic health care and hospital treatment programs. Case managers: 1) inform clients of the available and appropriate medical resources, 2) educate clients about benefits of receiving services in

particular adherence to treatment, and 3) act as advocates for PLHIV with health providers and insurance.

Client Documentation

- Description of all client contacts, attempted contacts and actions taken on behalf of the client
- Date and type of contact
- Description of what occurred during the contact
- Changes in the client's condition or circumstances
- Progress made towards achieving goals identified in the ISP
- Barriers identified in ISP goal process and actions taken to resolve them
- Referrals and interventions planned and/or provided
- Current status and results of linked referrals and interventions
- Time spent with, or on behalf of the client

Community setting

HIV primary health care and support services providers, as well as HIV testing sites, collaborate with case managers to promote HIV services to potential clients/families. Service provider networks, other care and support providers may post flyers in the neighborhood.

5. MoH Guideline – Principles of CM Services

MoH has not yet published guidelines for case management. However, principles can be extracted from the case management operational procedures (SOP).

Principles of Case Management:

1) CM coordinates a comprehensive package of care, support and treatment services that are promoted to the MSM community.
2) Basic standards for case management should be flexible and adaptable and address the rights and responsibilities of clients who are served.
3) Service delivery training and certification of case managers.
4) Develop regional or locally-based client intake forms, processes, and data management systems which decrease duplicative paperwork and streamline data collection.
5) Conduct regular meetings for case managers and/or case management conferences.
6) Formalize linkages through memoranda of understanding, agreements or contracts that clearly delineate the roles and responsibilities of each agency in the provision of comprehensive, integrated services for MSM.
7) Conduct cross-training and cross-orientation of different case management agencies serving clients living with HIV.
8) Designate someone in each agency to be a liaison with other HIV/AIDS case management agencies in the local community.

6. How can CSOs establish referral networks for CM services?

The referral network is the backbone of HCT and CM services (see HCT-referral network). Coordinating HCT with care and support services requires linkages and formalizing networks. A map and regularly updated referral directory of community and institutional care and support service providers, like case management and PLHIV support groups, should be available for all

health care providers and for people living with HIV. The directory should include the range of services offered, addresses, contact persons and relevant information.

Basic services for referral include:

1. NGO or primary health care facilities or clinics for HIV including treatment for opportunistic infections.
2. Case management program and psychosocial services.
3. Peer support groups and post-test clubs.
4. Income-generating groups or micro-credit organizations from stakeholders.
5. Home-based care programmers and those involved with food distribution to vulnerable households.
6. Sexual and reproductive health services including STI screening and treatment and contraceptive advice.
7. Suppliers of condoms and injecting equipment.
8. Drug substitution treatment services for MSM who inject drugs.

Two-way referral system from community to social or health care services and back to the community enhances flow in the referral process.

Steps for planning and managing a VCT referral network are as follows:

1. Find out about referral services in your district.
2. Identify service providers to include in the referral network.
3. Make a referral directory.
4. Make arrangements for referrals.
5. Establish a reporting and feedback system.
6. Maintain relationships to strengthen the referral network.

7. Resources, tools and materials

Staff

At service sites, the CM should ensure the number of trained staff (as required by MoH) is adequate to meet demand for services.

- One case manger for a total of 35 clients: 10 new clients and 25 follow-up clients.
- A program services coordinator (supervisor) is required for free-standing sites. In order to ensure optimal use of limited resources and maximum impact of services, coordination should take place at national level.
- Counselors, doctor, case manager, and laboratory technicians (where applicable) are expected to work as one team responsible.

Training CM Personnel

Standard comprehensive training should be provided to case managers to enable them to counsel and support MSM, network, and establish the referral network system. Basic training and additional follow up training and supervision should be made available for different categories of case manager.

The training topics for all categories must include:

- Overview of case management for HIV.
- Comprehensive prevention, care and treatment for HIV.
- Principles of case management.
- Program management/coordination and supervision. This includes monitoring and evaluation related activities, such as record keeping and reporting formats.
- Advocacy, networking and referral system.

Space and Equipment for CM Services

- One Counseling (CM) room
- Administrator/reception area
- Desk and two chairs (CM and client)
- Two steel filing cabinets
- AC or Fan (optional)

Materials

- National guide for Case Management that contains national policy and description of CM mechanism
- CM training curriculum

8. Monitoring

See the M&E section of this manual for more details on monitoring and evaluation.

The MoH established a set of performance quality indicators specifically for CM services. All CM sites collect data related to service uptake using recordkeeping and reporting formats approved by the subdit AIDS, Ministry of Health. The data are analyzed and interpreted to help adjusting, planning and decision-making. A monthly or quarterly report is prepared and submitted to appropriate authorities by the sites.

CM indicators include:

1) Client demographics (individual and couples)

And number of clients who:

2) Come to case management (HIV negatives)
3) Receive case management
4) Received HIV results
5) Have negative results
6) Receive ARV
7) Receive referrals and follow up
8) Receive family planning counseling
9) Receive psychosocial support
10) Receive food delivery
11) Receive help from case manager for incidents of stigma and discrimination
12) Use condoms with each sex contact for six continuous months
13) Bring in partner for VCT services

Key Resources

USAID SUM Program CD-ROM:

- Guide for case management—client form
- Monitoring Data Collection Tools, roles, responsibilities and frequencies (see implementation manual)

4.4.2 Home and Community – Based Care (HCBC)

1. CSOs – Role of facilitator to establish HCBC linked to health facilities

In small communities, home-based care may be the only way possible to ensure that PLHIV receive treatment and care on a regular basis. HCBC is a model of care that delivers health care and other support to PLHIV and their families. Services are provided by a mix of staff that usually includes community volunteers, a case manager, a support group, community health workers, nurses, doctors, and other professionals.

Table: HCBC Elements and Activities

Core Elements	Core Activities
Service package	Basic physical care Palliative care Psychosocial support and counseling Treatment of tuberculosis and opportunistic infections Food supplements
Administration	Network of services and resources Ensuring access to referral services • Transportation to referral services • Payment (ability to pay) Coordination with facilities • Discharge planning • Written referral Benefits to families: cash allowances, caregiver compensation, supply and storage of HBC kits, necessary drugs and commodities, and equipment. Staffing: supervision, recruitment, staff rotation between HBC and community clinic to avoid burn-out Budget and financial management, including income-generating activities • Quality assurance • Monitoring and supervision • Evaluation
Education/Training	Curriculum development Educational management and curriculum delivery Outreach activities Education to reduce stigma

Community Care and Support for Waria Living with HIV

A *waria*-led CSO employs VCT counselors and case management teams who are divided up to serve a particular municipality of the city. Each worker has a caseload that they maintain and refer their *waria* clients to services and support as necessary.

The CSO runs a shelter that provides a community care facility for *waria* living with HIV. *Waria* usually stay in the shelter when they are in the process of receiving treatment and therapy, for example, for tuberculosis where a *waria* must attend a clinic for treatment (DOTS) every day. The shelter also provides respite care when *waria* living with advanced HIV disease need help to recuperate and recover their strength after serious illness. Staff and volunteers monitor the health and care needs of residents in the shelter and provide their food. One *waria* VCT Counselor provides natural therapies for *waria* living with HIV. She runs meditation groups and is learning herbal medicine in order to provide supplements that can complement ARV and OI treatment.

Case managers work with *waria* living with HIV to assess their health and social welfare needs and to help *waria* move toward independently managing their health. One case manager and explains that "why I am working here is that I am HIV positive" and she believes that this makes it easier for *waria* with HIV to trust her. She often discloses her HIV status to clients and tells her own story of diagnosis and the benefits of health checking and ARV treatment. She first works with the newly diagnosed to help them "accept their status as [HIV] positive". After this she works on building self-esteem and helping them to "take care of themselves and stay healthy. If they have a problem with their health they can go to the doctor so that they can take the ARV by themselves not always dependent on me." In the beginning, she usually has to accompany them to their first series of hospital appointments but "after a month or two months this *waria* can go by themselves." She meets the *waria* in her caseload regularly at clinics in the city and tracks who is accessing services and who is not.

Something that makes her sad is that many who learn their HIV status are already living with advanced HIV disease and then there are "problems with the money and the cost and the living conditions" and in these situations "what we can do we can give encouragement" but this is hardly enough when poverty is the issue, she explains.

The CSO is responsible for the quality of care provided and ensuring that services follow HCBC standard operating procedures. In some settings, an existing body that coordinates health services may be able to fulfill this role.

Shelter Care for Waria Living with HIV

With their own funds, a *waria*-led CSO established a shelter for poor *waria* in need of emergency housing and assistance, and who may also have poor health. The shelter has become a center for HIV-positive *waria*, who are encouraged to be open to other community members and show them that you can live healthily with HIV. A founder of the CSO explains why it was so important to establish the shelter service for *waria* in Jakarta. "Most of the *waria* here are living in poverty and some of them are dying without knowing what should they do and who should be asked for help. There is little opportunity for us to work in a formal job... most of us are sex workers and beggars on the street... The shelter is really needed for us because many of the HIV-positive transgender are very poor, and some of them are dying on the street. It has made me so sad."

They have been able to sustain this small but important Shelter service with funding support from Social Welfare and from local district government.

2. Objectives

- To facilitate the continuity of patient care from the health facility to the home and community.
- To promote family and community awareness of HIV prevention and care.
- To empower the PLHIV, the family, and the community with the knowledge needed to ensure long-term care and support.
- To raise the acceptance of PLHIV by the family/community, hence reducing the stigma associated with HIV.
- To streamline patient/client referral from the institutions into the community, and from the community to appropriate health and social facilities.
- To facilitate quality community care for people living with or affected by HIV.
- To mobilize the resources necessary for sustainability of the service.

3. MoH Guidelines – Principles of HCBC Services

Although MoH has not yet published guidelines for HCBC, the recommended operational procedures (HCBC SOP) are as follows:

1) Take a multi-sector approach to care and support.
2) Ensure appropriate, cost-effective access to quality health care and support is available.
3) Encourage the active involvement of those most affected: the patient and families.
4) Mobilize the active involvement of those most able to provide support to the MSM community at all levels.
5) Target social assistance, including economic sustainability of the household to all affected families, especially children.
6) Support for caregivers to minimize the physical, emotional and spiritual demands that can come with the prolonged care of the terminally ill.
7) Ensure respect for the basic human rights of PLHIV.

8) Address the differential impact of gender on the care of persons living with HIV.

4. Steps: How CSOs can establish referral networks for HCBC services

Step 1: Create a network in the community, consisting of CSO, *Puskesmas*, support group.
Step 2: Determine function and responsibility of each party in providing care.
Step 3: The *Puskesmas* educates the community (and CSO) on providing care and support at home.
Step 4: The CSO helps the community establish an agreement with *Puskesmas* for follow-up care visits in home-based care.
Step 5: Monitor referral mechanism for home-based care as part of on-going quality improvement efforts.
Step 6: Integrate palliative care as a part of HCBC.

The following can be done to integrate palliative care:

- The hospital's palliative unit trains HCBC team in provision of palliative care.
- Provide routine supportive supervision and mentoring for the HCBC team.
- Equip HCBC teams with appropriate palliative care medicines.
- When possible, provide assistive devices to support home care (e.g., wheelchairs or bedpans)
- Follow up visit planned based on recorded patient intake, pain assessment (using the pain scale), and any other symptoms observed during patient evaluation.
- Include psychosocial assessment (including screening of alcohol and drug use) during patient intake and follow-up.
- Use client-held record (medical, psychosocial and economical and spiritual) where palliative and treatment plans are documented and updated as needs change.
- Ensure providers are trained in complementary healing techniques, for example massage, aromatherapy, relaxation therapy, etc.
- Team training and dialogue on danger signs can eliminate team member disagreement and blaming once the patient's condition deteriorates.
- Create formal service partnerships with Puskesmas, i.e., HIV out- and in-patient care facilities to promote client access to care. (Referral agreement)

- Established referral networks should include psychosocial support, spiritual care, legal services, and assistance to children.
- Provide counseling support including bereavement counseling for families and caregivers.
- HCBC team assists the family to make provisions for last rites, funerals, and burial.

5. Resources, tools and materials

HCBC requires an interdisciplinary team of professionals and caregivers and support group. The team crosses levels of service representing the continuum of care. The team includes health professionals, case manager, counselors, support group – PLHIV peers/expert patient trainer (EPT), nutritionist and spiritual support group. Patients and family caregivers are included in the team to empower them to take an active role in administering care. It is important to make strong links among team members so expertise of all disciplines can be used in the care for the FSW community. The team composition will depend on resources available.

- Home care services
- Transport services
- Facilities for respite care
- Shelters (*Kost, rumah singgah*)
- Feeding programs for children and adults
- Libraries
- Religious groups
- Mobile clinics
- *Puskesmas*
- Financial facilities/instruments
- Hospitals/institutions
- NGOs, CBOs, traditional healers (*tukang pijat*) and stakeholders
- Safety and security services

Equipment or materials:

- HCBC kit (first aid equipment and materials), drugs

HOME AND COMMUNITY BASED CARE KIT

1) Apron
2) Aseptol (disinfectant)
3) Burmeton (anti allergy)
4) B-6 Vitamin (for nausea and dizziness)
5) Ballpoint pen
6) Note book
7) Steel bowl and towel (for bathing)
8) Cotton
9) Vitamin C
10) Dicotil (loperamide, antidiarrheal)
11) Gauze
12) Gloves (disposable)
13) Gentian Violet (skin disinfectant/ulcers)
18) Oral rehydration salts (ORS)
19) Potassium permanganate (ulcer cleaning)
20) Talcum
21) Plaster
22) Soap and soap dish
23) Soda bicarbonate (dehydration)
24) Soap powder
25) Safety pins
26) Scissors
27) Tweezers (disposable)
28) Condoms
29) Plastic bags

Funerals and Burials

In many cases, families if they have financial resources, will arrange for last rites, funerals and burial. The HCBC team can assist the family with bereavement counseling, last rites, funerals, and burial.

Additional Medicines:

1) Anti-TB/DOTS (in close coordination with TB clinic and TB Zone team)
2) Analgesics, e.g. Aspirin, Paracetamol, and other more potent pain killers
3) A selection of medicines appropriate for treatment of opportunistic infections in Indonesia
    - Broad spectrum antibiotics
    - Antifungal
    - Antidiarrheal
    - Antitussive
    - Antiemetic
    - Malaria drugs specifically for Papua

Key Resources

USAID SUM Program CD-ROM:

- Alliance. *Positive Prevention: HIV Prevention with People Living with HIV*. 2006
- MoH, Republic of Uganda. *HIV Counseling and Testing*
- VCT Toolkit. *HIV Voluntary Counseling and Testing: A Reference Guide for Counselors and Trainers*. January 2004
- HCBC SOP

Monitoring Indicators for HCBC

Medical care

- Total patients and new patients consulted
- Number of patients on primary prophylaxis for opportunistic infections (cotrimoxazole)
- Number of patients who received home medical visits and care

Psychological care

Numbers of:

- Clients seen in counseling
- Clients who received home visits
- Home visits made
- People referred to support groups
- People trained in communities

Social and nutritional care

Numbers of:

- People supported for para-clinical check-ups
- Meals/breakfasts served
- People who received meals/breakfasts
- Food packages distributed

4.5 Support

4.5.1 Support Group

People with the same condition typically feel safe and find it easier to discuss feelings, problems and solutions within a peer support group. Support groups create a forum for people with a similar condition to learn from each other on coping with living positively with HIV. Support groups have proven to be very useful for MSM for reinforcing positive prevention. Members sometimes serve as peer educators in their communities and some have been recruited as counselors to reduce stigma and discrimination.

1. Importance of Support Group Services for FSW

Support groups for HIV-positive MSM contribute towards reducing stigma and discrimination in the neighborhood. PLHIV involvement can also enhance planning, development and delivery of care and support services for HIV-positive MSM. Support groups can help the MSM community create a culture that is conducive to promoting positive prevention, quality of life issues and compassion for people living with HIV.

2. Promotion of Support Group Services (Demand Generation)

HIV-positive people are introduced to a CSO that has established support groups. They and their families are invited to join support group activities. Support groups open the door to more meaningful involvement of people living with and affected by HIV, as peer counselors, educators, advocates and leaders.

3. Types of Support Group Services

Peer Support

Peers meetings allow the sharing of feelings and information, and provide mutual support to members. Peers facilitate acceptance of one's status and enable people to realize that they are not alone. It can also assist in disclosing status to family or loved ones.

Peer Education

Living with HIV can be very complex. Difficult questions frequently arise, such as dealing with personal relationships, having children or choosing treatment regimen options. Many people living with HIV find it helpful to become an expert on some aspects of living with the virus. PLHIV are in a position to pass this knowledge on to their peers with authority and sincerity. PLHIV can be trained to become treatment educators, who train on antiretroviral medication, treatment regimes, adherence issues, and side effects.

Advocacy

Positive people can be very influential as advocates. They can lobby for improved treatment and care on an individual or group level, as well as raise awareness of issues at policy-making level. Elected officials are sometimes more willing to support people who benefit directly from their actions (such as approving budgets for treatment and care) rather than those who benefit less directly (via targets of prevention programs).

Public Education

Positive people who speak out openly and put a human face on HIV break the code of silence that surrounds HIV and AIDS. Most people untouched by the epidemic assume that HIV has nothing to do with them, and therefore, turn away from opportunities to learn more about the disease. Positive people can change the perception from “them” to “us”.

Counseling

People living with HIV can also be trained as counselors, case managers or outreach workers. An effective peer can help dispel fears faced by most people during testing or by those who are newly diagnosed. With the increased pressure of governments to test more people for HIV, qualified, effective counselors are key people.

Program Planning and Implementation

The experience of people living with HIV can be useful for improving service delivery programs. For example, prevention messages may add to AIDS-related stigma and discrimination. Having such messages checked by PLHIV before they are released can minimize this risk. Also, a common challenge faced by organizations working in HIV is staff turnover. Burnout is common, and after a few years, staff may move to less stressful work in other fields. People living with HIV tend to have more sustained commitment and are models for positive living with ART.

Public Health Policy and Legislation

Positive people are often asked to participate as members in national and provincial AIDS commissions and have opportunities to participate in committees discussing AIDS-related legislation. The Indonesia Coordinating Board concurred that members of community-based organizations must have a voice, including people living with HIV. Involvement of PLHIV can help avoid potentially discriminatory actions or legislation.

4. Objectives

- Enable people to learn from each other on positive living with HIV.
- Receive accurate information about HIV/AIDS, how to live with the virus, and adhere to ART.
- Reinforce the benefits of other care and support.

5. MoH Guideline – Principles of Support Group Services

The MoH has not yet provided principles for support group services. The following are USAID SUM Program principles for support group services. See also CCM National Guidelines for Care, Support and Treatment.

Principles of Support Groups

1) Support groups encourage open communication, sharing accurate information, problem solving and mutual support to reduce transmission of HIV and positive living.
2) PLHIV participation in planning can help in applying strategies to the local context. Acceptance and involvement at community level can increase the self-esteem and confidence of HIV-positive people to protect their own sexual health and avoid passing on HIV infection to others.
3) Promoting human rights is an important aspect of support groups and should include the right to health, privacy, confidentiality, informed consent, freedom from discrimination, the duty to do no harm.
4) HIV transmission is fuelled by inequalities in power due to gender inequality, sexuality, knowledge, societal roles and poverty. Support groups can ensure that HIV prevention strategies do not further stigmatize those marginalized communities.

6. Considerations Facing Support Groups

Support groups are formed in response to the needs of its members and are enhanced by a sense of voluntarism and charity. Over time members develop a commitment to each other and offer to contribute financial and other necessities for member survival. Support groups usually are not dependent on funding from government agencies. However, it is important for partnerships to be developed between group, family, and community-based organizations and local health departments and other health service providers. Roles and responsibilities of all actors and benefits derived from partnerships should be fully explored.

7. Resources, tools and materials

Capacity building for HIV-positive support group facilitators should include:

- Personal empowerment
- Positive prevention
- Communication and presentation skills
- HIV and AIDS technical knowledge
- Organizational development skills
- Legal aspects of HIV and AIDS
- Leadership skills and representational skills
- Policy analysis
- Documenting and reporting skills.

Resources

The support group facilitator has a vital role, using his or her experience of living and coping with HIV. The facilitator is a member of the group and runs sessions based on the needs of the group members. They should be well trained, receive support for this role and be properly remunerated.

Facilities

Space should be available for regular MSM-support group meetings. People have concerns about confidentiality and privacy. There is evidence that assurance of confidentiality and trust facilitates disclosure of risk behaviors. It is imperative that the room is private and comfortable for FSW.

Materials

- Training materials and tools
- Data collection and reporting materials

Key Resources

USAID SUM Program CD-ROM:

- *National Guideline for Care Support and Treatment*, MoH

8. Monitoring

Monitoring indicators for support include – Number of MSM living with HIV and their families:

- Participating regularly in meeting support
- Trained with capacity building program
- Employed by CBOs or NGOs as staff members

4.5.2 Counseling

1. Scope: Why access to counseling is important for MSM

Counseling offers MSM time, attention and respect in a two-way dialogue with a trained professional to explore, discover, and clarify ways of living. Counseling is an issue-centered, goal-oriented interaction, and involves examining and weighing options for decision-making and behavior change. Effective counseling helps another person to be autonomous, i.e., to make his/her own choices and decisions, and be responsible for his/her own actions.

2. Promotion of counseling services (demand generation)

Voluntary counseling and testing for HIV is promoted to clients and can be an entry point for on-going counseling to meet client needs for treatment adherence, partner counseling, family counseling, and addiction counseling. The counseling method is generally based on clients' needs and circumstances including their psychological state, the type of problem, and the stage of the problem. A client may need different types of counseling either at the same time or over the course of time. Counselors may also refer a client to alternative or supplementary services such as community-based or self-help groups which can provide on-going emotional support.

3. Enable FSW to access counseling services

Types of counseling services:

a. Partner Counseling and Referral Services

Partner (couple) counseling and referral services (PCRS) are part of the spectrum of care for HIV-positive people and their sexual partners. Referral includes notifying partners of exposure, after which they are offered HIV testing and receive prevention or risk-reduction counseling. If they test HIV positive, they can be referred to care and treatment services. Referral should always include efforts to facilitate the initial contact with service providers. PCRS referrals should be documented. Three follow-up attempts should be made to confirm success in accessing the service.

b. Adherence Counseling

Adherence is when a patient takes the appropriate drugs, in the right dose and frequency, at the correct time of day as prescribed by the healthcare provider. During ART adherence counseling the counselor tries to help the client to follow the treatment exactly as prescribed. 100 percent adherence to ART is required for the body to fight the HIV virus. Poor adherence leads to drug resistance, increased viral load, increased illness, and increased possibility of death.

c. Family counseling

The support of family and friends can help an MSM who is living with HIV. Family counseling can take a variety of forms. Examples include counseling family members on how to behave toward someone who is living with HIV, helping them to understand that the person needs affection like any other and should be treated as normally as possible. Another example is when family members may need psychosocial support to help them cope with stigma and discrimination that they may encounter in the neighborhood, at school, at work, or elsewhere. In many cases, families have misgivings about living with someone who has HIV. Counselors should reassure family members that HIV is not transmitted through day-to-day social contact. They need to know they can play or eat with a person who is HIV-positive without any risk of infection. But the counselor should also explain the slight risk of infection through contact with an infected person's blood, and on what precautions should be taken in the home when caring for individuals living with HIV.

4. Objectives

Partner Counseling and Referral Services

Counselors will be able to:

- Promote early knowledge of HIV status through HIV testing and ensure that all persons either recommended or receiving testing are provided information on HIV transmission, prevention, and the meaning of HIV test results.
- Help clients gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention and support services.
- Increase CSOs' awareness of resources and ability to provide the most effective and comprehensive support to clients.

Adherence Counseling

Counselors will be able to:

- Help clients achieve 100 percent treatment adherence.
- Enable clients to
  - Understand the regimen
  - Believe they can adhere
  - Remember to take medicines at the right time
  - Integrate the prescribed regimen into their lifestyles
  - Problem-solve changes in schedule or routine.

Family counseling

Counselors will be able to:

- Win over families and communities to support MSM living with HIV, to live together and improve their quality of life.
- Help families and community to understand and accept the HIV status of individuals without blame, stigma or discrimination.

5. MoH guidance on counseling services for FSW

The Ministry of Health (Subdit AIDS - *AIDS Unit*) is responsible for ensuring that all counseling standards are met. Guidelines for counseling are drawn from: VCT TOOLKIT, HIV Voluntary Counseling and Testing: A Reference Guide for Counselors and Trainers, January 2004, VCT TOOLKIT Family Health International.

Elements of Good Counseling

Ample Time
Providing the client with adequate time is important from the very beginning. The counseling process cannot be rushed: time is necessary to build a helping relationship.

Acceptance
Counselors should not be judgmental of clients, but rather should try to accept clients, regardless of their socioeconomic, ethnic, or religious background, occupation, or personal relationships.

Accessibility
Clients need to feel they can ask for assistance or call on a counselor at any time. Counselors need to be available to clients at appropriate times and should have systems in place to respond to clients' needs as appropriate (e.g. provide services after hours or work during lunchtime on a rotating system).

Consistency and accuracy
Information provided through counseling (e.g., about HIV infection, infant-feeding options, infection risk, and risk reduction) should be consistent both in content and overtime.

Confidentiality
Trust is the most important factor in the counselor-client relationship. It enhances that relationship and improves the odds that an individual will act decisively on the information provided. Given the discrimination, ostracism, and personal recrimination an individual diagnosed with HIV may face, it is all the more important to guarantee confidentiality.

TCEUA

Effective counseling involves, trust, communication, empathy, understanding, and action (TCEUA).

Trust: Trust enhances a relationship and improves the odds that an individual or group will act decisively on the information provided. Trust can be gained by ensuring privacy and confidentiality, attending and listening, showing respect, and developing rapport.

Communication: To identify a client's needs and provide the right information, the counselor must communicate in a way that is clearly understood. Counselors should focus on two basic communication components: *content* and *feeling*, using both verbal and non-verbal techniques.

Empathy: Genuineness, unconditional positive regard, and non-judgmental behavior are key to effective counseling. Empathy in turn leads to ...

Understanding: It is important to understand the client's problems and related thoughts and anxieties; determine who is "in charge" in the counseling session; and assess options that will lead to taking *action*.

6. Considerations related to counseling people living with HIV

Counseling is driven by the client's needs. Counselors cannot fulfill all client needs and these limitations should be made clear during counseling. However, the counselor can help connect the client with additional resources within the community. The family, community, religious groups, self-help groups, health care facilities, NGOs, development partners, etc. can all play a role in supporting the client.

Needs for prevention, care, support and treatment services are assessed and prioritized, and MSM are assisted to access these services, e.g., setting up appointments, providing transportation, etc. Referrals should address highest-priority needs, be culturally sensitive, and be appropriate for differences

Basic Elements of Effective Counseling Referral System:

- Offers clear, specific, and up-to-date information
- Ensures confidentiality
- Access to counseling is easily arranged
- Counseling is in a safe setting for the client
- Uses a multi-sectoral/multi-disciplinary approach
- Offers several referral options to the client
- A clear communication system links the VCT center, case management services and other care and support services
- Absence of discriminatory practices by service providers
- Documentation of counseling session, referral and follow-up.

related to language, gender, sexual orientation, age, and developmental levels.

Clients have complex needs that may affect their ability to adopt and sustain behaviors. Counselors should identify key factors likely to influence the client's ability to adopt or sustain behaviors including the client's willingness and ability to accept and complete a referral. Counselors must be sensitive to the changing feelings of clients as they access various care and support services.

7. Resources, tools and materials

Staffing

VCT Counselor, paramedic and case manager work as one team responsible for many activities and/or issues related to counseling. The team must have received training, as required by the MoH.

Minimum Staff requirements:

- One **counselor or paramedic** for VCT or for PITC
- One case manager

Space for Counseling Services

One counseling room in the clinic, hospital or CSO office:

Equipment and supplies

- Desk and three chairs (counselor, client, and partner)
- Two steel filing cabinets
- AC or fan (optional)
- Glass, water, tissues and IEC Material (e.g., condoms)

Reception/Administrator Room

- Cash box
- Desk and chair
- Two upright chairs
- Steel filing cabinet
- Office supplies
- Telefax machine
- Computer for data entry (optional)

Counselor Training Topics:

Standard comprehensive counselor training should include:

1) Updated HIV/AIDS information
2) Counseling concepts, features, and skills
3) Behavior-Change strategies and adherence
4) Positive prevention
5) Physical and psychological care, coping, and support
6) Grief and bereavement
7) On-going counseling
8) Counselor burnout and stress management
9) Monitoring, supervision, and quality assurance
10) Home-based care

Materials

- National policy issues and plans regarding VCT on-going services and National policy on care, support and treatment
- Data collection and reporting materials
- Data flow system of HIV/AIDS program and referral documents

Monitoring Indicators

The MoH has established a set of specific performance indicators for counseling services in Indonesia, including – Number of clients who receive:

- adherence counseling
- disclosure counseling
- partner counseling
- family planning counseling
- couple counseling
- suicide counseling
- referral and follow up

Key Resources

USAID SUM Program CD-ROM

- *Monitoring Data Collection Tools, Roles, Responsibilities and Frequencies*
- *FHI VCT Toolkit. Voluntary Testing and Counseling: a Reference Guide for Counselors and Trainers. 2004*

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5. Treatment

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5.1 TB Treatment

1. Importance of Access to TB services

Indonesia is globally the fifth highest in reported TB cases. TB is the number one cause of death in Indonesia. However, this disease can be cured if the complete regimen of medication is taken as directed.

2. Objectives of TB Services

- To treat TB
- To prevent TB transmission to others
- To reduce mortality rate among PLHIV due to TB co-infection

3. MoH Guidelines – Principles of TB Treatment

- Anti-tuberculosis treatment is given as a combination of several drugs.

- Treatment must be conducted under direct supervision (DOTS – Directly Observed Treatment Short-course): through observation of swallowing of drugs.

- The six to nine month treatment is in two phases: intensive and continuation. During the intensive phase, medication is taken every day for two months. Note: a person is no longer infectious after two weeks of treatment, although not all germs have been killed. The continuation phase is essential for killing germs, which is why complete compliance is necessary.

4. Education and Promotion of TB Services (demand generation)

Key messages:

1) TB is transmitted by those who have TB bacteria in their sputum.
2) TB is usually contracted through inhaling small, airborne droplets that contain the bacteria, and are spread when the person coughs, sneezes or talks.
3) Most infections occur in a room that lacks ventilation and sunlight. Germs can survive for a long time in damp and dark environmental conditions.
4) TB mostly infects the lungs.
5) TB is not a hereditary disease.
6) Persons with low immunity are more susceptible to contract TB, for example people with HIV. HIV is the strongest risk factor for contracting TB.
7) TB and HIV often occur together (co-infection) and can worsen the immune system and the ability of the person to fight other infections.

8) Coughing etiquette: help prevent spread of TB by covering the mouth with a tissue or handkerchief when coughing or sneezing.

5. Enabling FSW to Access TB Services

Symptoms to note:

- Coughing more than two weeks
- Cough or sputum mixed with blood
- Shortness of breath
- Chest pain
- Sweating at night, even without activity
- Lumps in armpit or neck
- Weight loss
- Malaise
- Fever more than one month.

When clinical symptoms appear, refer the person directly to a health care facility that provides TB treatment services. TB drugs are available free of charge at *Puskesmas*.

6. What can the CSO do to Support the TB program?

1) Immediately refer the person to the nearest *Puskesmas*.
2) Assist the patient taking the medication.
3) Provide basic information and education about TB prevention, symptoms, transmission and treatment.
4) Reinforce compliance with the complete treatment regimen (6-9 months).

7. How are CSOs able to establish Referral Networks to TB Services?

Refer the patient to government facilities immediately. Drugs are free and available to the patient. However, the patient is responsible for paying sputum smear examination.

To deliver referral services, CSOs need to know:

- Location of the nearest TB services
- Contact persons at all facilities providing services
- Opening hours of services
- Cost to be paid by the patient

Key Resources

USAID SUM Program CD-ROM:

- *Pedoman Nasional Penanggulangan Tuberkulosis*, Departemen Kesehatan, Republik Indonesia. 2007
- WHO, *Global Tuberculosis Control*, 2010
- IEC, *Cough Etiquette*

5.2 OI Treatment

1. Importance of access to OI Treatment Services

PLHIV often suffer from opportunistic infections (OI) due to lower immunity, and are susceptible to infections that generally do not cause disease in persons with a normal immune system. PLHIV usually do not die from HIV, but from complications from HIV-related OI. Treatment for HIV-related OI is integrated with ART services. Regular check-ups are essential to manage treatment for OI and HIV.

2. Objectives

- To reduce morbidity and mortality rate among PLHIV
- To improve quality of life of PLHIV

Key Resources

- *Pedoman Perawatan, Dukungan dan Pengobatan HIV*, Departemen Kesehatan Republik Indonesia, 2007
- WHO, *Antiretroviral Therapy for HIV Infection in Adults and Adolescents in Resource-Limited Settings: Towards Universal Access*, 2006
- WHO, *Antiretroviral Therapy for HIV Infection in Adults and Adolescents*, 2010 revision
- WHO SEARO, *Management of HIV Infection and Antiretroviral Therapy in Adults and Adolescents; A Clinical Manual*, 2007

3. MoH Guideline – Principles of OI Treatment Services

- OI treatment should be completed before ART
- Types of OI treatment services available
- Main OI for CSO involvement are TB, oral candidiasis, chronic diarrhea

4. Education and promotion of the OI Treatment Services (demand generation)

Key messages:

- Presence of OI is a risk to infect others.
- Each OI requires specific medicine.
- OI should be treated first before beginning ART.

5. Enable PLHIV to access OI Treatment Services

Assist and accompany PLHIV for OI treatment and support. CSOs can support adherence to medication.

6. What can the CSO do to Facilitate Treatment?

- Provide information and education about OI.
- Assist in adherence to OI treatment.

7. How CSOs are able to establish Referral Networks into OI Treatment Services.

To deliver referral services CSO needs to know:

- Location of the nearest OI clinic
- Contact person in the clinic providing services
- Opening hours of services
- Costs to be paid by the patient

5.3 Cotrimoxazole Preventive Treatment (CPT)

1. Importance of access to CPT Services

For PLHIV, the immunity to infection is reduced, which can result in opportunistic infections (OI). Some OI can be prevented by cotrimoxazole preventive treatment (CPT). CPT can prevent brain abscess caused by toxoplasmosis, and *Pneumocystis jerovecii* Pneumonia (PCP), and chronic malaria.

2. Objectives

- To prevent several OI in PLHIV

3. MoH Guideline – Principles of CPT Services

CPT principles:

- CPT is given to PLHIV with clinical stage 2, 3 and 4.
- If CD4 count is available, CPT is given to PLHIV with CD4 <350 cells/mm^3
- CPT is given to all TB-HIV co-infection patients.
- CPT is given continuously to PLHIV on ART until there is proof of improved immunity.
- Pregnant and breastfeeding women who need CPT can still take CPT regardless of stage of pregnancy (trimester).

4. Education and promotion of the CPT services (demand generation)

- CPT is cheap, easily implemented and effective to prevent common OI in PLHIV.
- CPT is part of HIV chronic care and an important component of pre-ART treatment.
- CPT is given continuously to PLHIV on ART until there is proof of improved immunity.

5. Enabling FSW to Access CPT Services

CPT services are an integral part of ART services. Health facilities (*Puskesmas*) that have HCT services can also give CPT, because cotrimoxazole is available in *Puskesmas*.

6. What can CSO do to Facilitate Treatment?

- Refer PLHIV to CPT services to get information and CPT on time
- Assist in adherence to CPT
- Provide information and education about CPT

7. How are CSOs able to establish Referral Networks to CPT Services?

To deliver referral services CSO needs to know:

- Location of the nearest CPT services
- Contact person in the services
- Opening hours of services
- Cost to be paid by the patient

Key Resources

- *Pedoman Perawatan, Dukungan dan Pengobatan HIV*, Departemen Kesehatan Republik Indonesia, 2007
- WHO, *Guidelines on Co-trimoxazole Prophylaxis for HIV-related Infections among Children, Adolescents and Adults*, 2006

5.4 HIV Treatment (ART)

1. Importance of access to ART services

Antiretroviral therapy (ART) inhibits viral replication of HIV so that the immune system has a chance to recover. This leads to an improvement in the health and quality of life of PLHIV. ART medicines are free at government facilities. Not all PLHIV will start ART immediately after diagnosis. It depends on clinical and immunological assessments by the doctor.

2. Objectives of ART

- To reduce morbidity and mortality among PLHIV
- To improve quality of life of PLHIV

3. MoH Guideline – Principles of ART Services

- ART is a combination of several drugs
- ART is taken regularly and on-time
- OI need to be treated before starting ART
- ART counseling is necessary so that PLHIV understand:
    - Benefits of ART
    - How to take ART
    - Side effects and issues related to ART
- Key individuals can supervise the patient in taking the medication
- Patients should be monitored and examined regularly

4. Education and promotion of ART services (demand generation)

Key messages:

- ART inhibits viral replication, thereby preventing disease progression and immune system damage.
- The immune system has a chance to recover and resist OI.
- ART does not kill the virus. ART should be taken for life, even if symptoms have disappeared and the patient feels well.

CSO – Case Management and Continuity of Care

One PLHIV tells how almost every time she goes to the hospital the doctor has changed. The biggest hospital is a teaching hospital, so doctors are rotating every one to three months. She wants to have a stable relationship with a team of practitioners, the same doctor each time. Previously CD4 counts were free and now she has to pay. Every time the doctor changes the new doctor always asks for a CD4 test again.

- Safe sex practices should be used since the virus is still in the body.
- ART must be taken regularly and on time to be effective and avoid drug resistance.

5. Enable PLHIV to Access ART Services

Refer FSW to ART services as soon as possible so as not to delay start of treatment. Even if patients do not yet meet criteria for starting ART, they should be checked periodically by a health worker in order to detect OI.

6. What can the CSO do to Facilitate Treatment?

- Assist in treatment adherence to ART protocol
- Provide information and education about HIV and ART

7. How are CSOs able to establish Referral Networks to ART Services?

To deliver referral services, CSO needs to know:

- Location of the nearest ART services
- Contact person at the clinic providing services
- Opening hours of services
- Costs to be paid by the patient

8. Locations for ART Service

ART services are mostly available in hospitals. ART may be available in some *Puskesmas* or prisons (linked to hospitals).

Key Resources

- *Pedoman Perawatan, Dukungan dan Pengobatan* HIV, Departemen Kesehatan Republik Indonesia, 2007
- WHO, *Antiretroviral Therapy for HIV infection in Adults and Adolescents in Resource-Limited Settings: Towards Universal Access*, 2006
- WHO. *Antiretroviral Therapy for HIV Infection in Adults and Adolescents*, 2010 revision

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6. Enhanced Involvement of MARPs

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6.1 Setting Up a Peer Education Program

1. Scope

Peer education is a structured, interpersonal form of communication that uses trained members of beneficiary populations on an ongoing basis to influence their peers to undertake behavior change to improve or protect their health and to maintain positive behaviors. Peer education assumes that people are more likely to be influenced by members of their own peer group than by "outsiders." This is because they are more likely to identify with and trust them. Peers are determined by demographic factors (age, place of residence, occupation, level of schooling) and social factors (social networks engaged in similar behaviors, lifestyles, etc.)

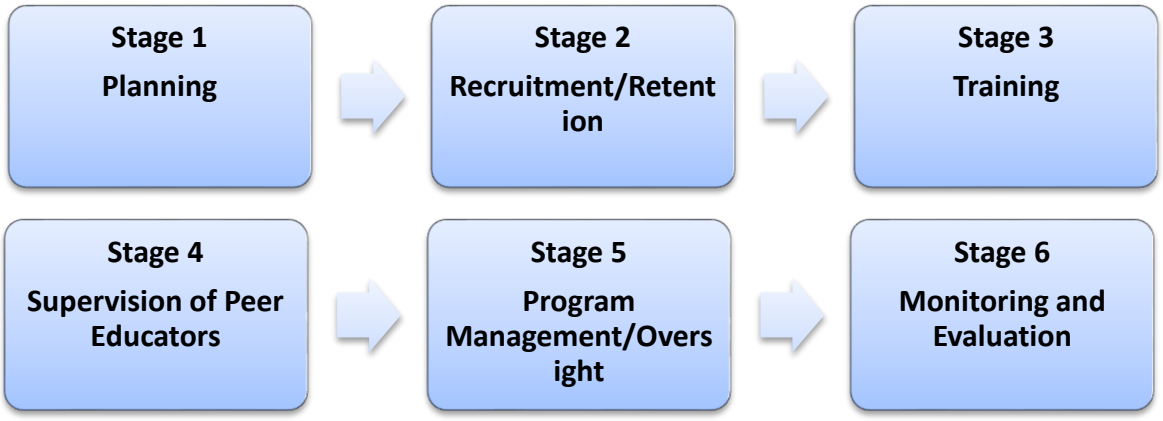
This section is intended to provide general guidance for setting up peer education interventions, as part of a BCI strategy.

Peer education is a common component of HIV programs. However, peer education programs often face challenges that can diminish or impede their effectiveness. The steps and implementation procedures outlined below are intended to address the most challenging areas of peer education. These include: planning; recruitment and retention of peer educators; training; supervision; management and oversight; monitoring and evaluation.

2. Objective

To develop a peer education program based on a participative process to enable peer educators to influence behavior change among their peer group through communication, providing information, health education, referrals and role modeling.

3. Stages



Stage 1	Planning
a.	Mobilize key stakeholders. Ensure that relevant stakeholders (including government officials, civil society leaders, health professionals, education leaders, youth groups, etc.) are informed and encouraged to support peer education efforts.
b.	Ensure active participation of beneficiary population. Actively involve beneficiary populations in the planning process so that their needs and preferences are identified and used to define the PE program.
c.	Identify beneficiary populations' needs. Assess specific needs of beneficiary populations through formative assessments, surveys, and informal means. Make sure relevant representation of each beneficiary population is included in the assessment.
d.	Develop a workplan. Develop a workplan (with objectives, strategies, activities, partners, timetable and budget). It should include training plans, a communication and advocacy strategy, materials/tools development or adaptation, community involvement, and a monitoring and evaluation (M&E) plan. The M&E plan should include: qualitative and quantitative indicators, data collection instruments and systems, timetables, responsible parties, reporting channels, etc.
e.	Identify available resources and try to fill gaps. Identify resources needed to deliver program activities (based on program needs). Include resources that are obtainable as well as existing gaps requiring attention.
f.	Consider cross-cutting issues. Incorporate key contextual concerns (such as sexuality, gender, socio-cultural factors, vulnerability, age) into the planning.
g.	Establish feedback mechanisms. Incorporate channels through which beneficiary populations and stakeholders can share their views about the program and make suggestions for improvement.
h.	Coordinate and establish linkages with other programs. Establish multi-sectoral involvement with key stakeholders, partners, and other programs through joint programming, coordination, and linkages of activities.
i.	Develop a plan for resource mobilization and sustainability. Develop a plan for adequate and timely funding of program activities, along with a plan that fosters institutionalization, ownership, and other mechanisms to ensure that activities are sustained beyond the program's term.
Stage 2	**Recruitment and Retention**

a.	Identify sources and channels for recruiting peer educators. Work with partner organizations, workshop participants, beneficiary population groups and community leaders to develop a plan to identify recruitment sources and channels (word of mouth, announcements, mass media, yellow pages, Internet, etc.)
b.	Develop and agree upon selection criteria for peer educators. Develop a list of agreed-upon criteria for selecting peer educators. The criteria should include availability, age, motivation, acceptability by beneficiary population, previous experience, personal traits (behavior, team player, volunteer spirit, potential for leadership, etc.), and other characteristics deemed relevant for a particular program.
c.	Set clear expectations. Document the clear expectations of both the program and prospective peer educators. Expectations for peer educators' activities and performance need to be clarified and documented in writing. This should be agreed upon by all partners at the beginning.
d.	Establish a standardized and transparent interview and selection process. Standardize and document the interview forms and process, including establishment of a credible recruitment panel. The selection process needs to be documented in writing, made available to all interested parties, and should be implemented fairly.
e.	Establish means for continuous communication, including feedback. Establish open and continuous communication mechanisms between peer educators and the program supervisors and managers, including regular feedback via supervision, regular peer educator/management meetings, and an annual retreat (if possible).
f.	Establish an incentives system. Create a system of reinforcement and non-financial incentives, including: recognition; awards; social and recreational opportunities; exchange (and travel) opportunities; and advancement within the group as appropriate.
g.	Establish supervisory and mentoring systems. Set up an effective supervision system, with mentoring provided as possible.

h.	Offer opportunities for increasing involvement and responsibility. Encourage peer educators to become more involved and take on additional responsibilities where possible, including assumption of some program operation tasks (co-trainer, management assistant, recruiter, etc.).
Stage 3	**Training**
a.	Arrange for qualified trainers. Hire trainers that are well informed, prepared with knowledge and skills relevant to their responsibilities, flexible and able to improvise, tolerant, experienced in peer education, and sensitive to cultural and gender issues. They can work as co-facilitators, place the group's concerns before their own interests, and are able to work well with the selected training curriculum.
b.	Select quality training curricula. Select training curricula that are consistent with the topics and approach of the program/BCI strategy, culturally appropriate and gender sensitive, interactive and participatory, and well structured and sequenced in feasible time allocations.
c.	Arrange for appropriately sized trainee groups. Training workshops should not exceed 15-20 participants to allow for effective participation, full interaction among peers and trainers. This group size also offers opportunities for leadership and skills practice.
d.	Provide relevant materials and handouts. Provide participants with materials in advance and during training sessions, as appropriate, including practical handouts and materials for exercises. Copies of reference and review materials should also be provided at the conclusion of the training.
e.	Use interactive, participatory, and skills development approaches. Use participatory training approaches that maximize trainee participation, such as interactive exercises, opportunities to practice new (or important existing) skills, and role play of situations participants are likely to encounter as peer educators.
f.	Implement tools and methods to evaluate training and training participants. Include mechanisms for assessing trainees' knowledge and skill development from the onset of training (as a baseline) and used at the conclusion of the

	training (post-training evaluation). Tools for trainees to evaluate the training should also be included.
g.	Discuss ethical issues. Highlight and discuss ethical issues (such as confidentiality, power balance, gender equity) that are likely to arise in connection with peer educators' activities as part of the training.
h.	Involve beneficiary population at all stages. Beneficiary populations need to be involved in all aspects of the training design, implementation, and evaluation, and should also help plan future training.
Stage 4	**Supervision of Peer Educators**
a.	Arrange for trained supervisors. Hire/recruit supervisors who have been trained in supervision skills, program expectations, and peer education content and approaches.
b.	Ensure that peer educators are well prepared. Supervisors have to ensure that peer educators have received adequate preparation (through training and skills acquisition/practice) before they begin their work. Updates of knowledge and skills should be provided as needed, and with expansion of roles.
c.	Continually reinforce motivation and ethical behavior. Supervisors should continually reinforce the personal or professional motivation of peer educators (via rewards, meetings, etc.), reinforce compliance with the code of ethics, and monitor sensitivity to gender and cultural concerns. Where possible, supervisors should promote opportunities for personal development, such as workshops and conferences.
d.	Manage the group dynamic and encourage team building. Supervisors need to manage the group dynamic, encourage team building, promote a safe environment, and stay aware of personal relationships.
e.	Share responsibility with peer educators. Supervisors should build ownership by involving the peer educators in the decision-making process, sharing supervision and responsibilities with peer educators and involving them as active participants in the supervision process, with feedback regularly invited.

Stage 5	Program Management and Oversight
a.	Ensure compliance with program standards. Management staff (internal and/or external) need to systematically monitor and assure compliance with standards and initiate corrective action when shortfalls are identified.
b.	Ensure technical competency of management team. Management staff need to demonstrate technical competencies in specific areas appropriate to their responsibilities, including peer education strategies and methodologies, behavior change intervention (BCI) strategy and activities, and M & E.
c.	Establish and maintain quality expectations. Both management and peer educators have to establish guidelines and expectations about the quality of various PE activities (e.g., conducting small group discussions, organizing events, making useful referrals) and developing remedies when quality standards are not being met.
d.	Establish effective administration of human and financial resources. Establish effective systems for managing human/financial resources, with trained, competent staff responsible for carrying them out.
e.	Establish a transparent decision-making process. Ensure that decisions about program operations are clear, consistent with program policy and culture, and can be documented as necessary.
f.	Establish a process for beneficiary population participation in decision-making. Beneficiary populations should have a role in making decisions about the management of the program and provide their perspective on program decisions.
g.	Use M&E for decision-making. Findings from timely reporting on program activities, as well as from any evaluation that takes place, should be used to make adjustments in program operations and the BCI strategy and for planning future activities.
h.	Promote cooperation and networking. Promote cooperation with partner agencies and institutions and foster networking to increase reach and breadth

	of program activities.
i.	Establish linkages and referrals to services and commodities. Both management staff and peer educators need to assure a functioning system of linkages to appropriate services and commodities is in place to supplement the program's services.
j.	Establish sustainability plans. Management staff should maintain a feasible plan to mobilize resources for the life of the program and to foster sustainability beyond the program's term.
Stage 6	**Monitoring and Evaluation of Peer Education**
a.	Establish relevant, clear objectives. Develop clearly defined communication and behavior objectives that are measurable, time-bound, and achievable, i.e. SMART objectives.
b.	Develop functional, relevant indicators. Include indicators that reflect gender, age, religion and, ethnicity and that allow tracking and measurement of beneficiary population performance and success of program activities (such as drop outs, number of stakeholder meetings, number of beneficiary population reached, number of peer education activities, etc.) in M&E plan. Define "reached" as specifically as possible.
c.	Include M&E in the workplan from the start. Include an M&E plan, with an allocated budget in the workplan at the program's start. The plan should capture all aspects of the program, including recruitment, training, peer education activities, supervision, peer educator performance, beneficiary population involvement, gender equity, and collaboration.
d.	Implement baseline assessment. Conduct baseline assessment, against which to measure achievement of objectives before the start of peer education activities.
e.	Develop monitoring tools and a measuring system. Design, develop and/or adapt tested and usable monitoring tools (questionnaires, diaries, tracking forms, etc.) as part of the M&E system for monitoring and for measurement of performance and progress. Staff and peer educators need to be trained in how to use them.

f.	Ensure capacity to plan and implement M&E. Build capacity of program staff to plan and implement M&E, OR identify appropriate external support and assistance for M&E.

4. Resources, tools and materials

- Trainer
- List of key stakeholders
- Needs assessment tool
- List of selection criteria
- Interview guide for selection process
- Training curricula
- Training materials and handout
- Supervision and evaluation tools
- Referral cards
- Condom, lube and dildo
- IEC materials

Key Resources

USAID SUM Program CD-ROM

- *Peer Education Standard Operating Procedure (SOP)*

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7. Enabling Environment

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7.1 Structural Interventions and the Enabling Environment

The challenge of HIV prevention is to reduce STI prevalence and increase consistent condom use among *waria* through a comprehensive and integrated STI control program. For the program to be effective, four key components are needed:

- A conducive environment to support the implementation of a comprehensive and integrated STI prevention program, (one linked with HIV care, support and treatment);
- Prevention education, risk-reduction messages, behavior change interventions for practicing safer-sex behavior (including consistent condom use) and appropriate health seeking behavior for individuals and groups of *waria*;
- Condom provision, distribution and promotion continually and extensively in areas where *waria* meet;
- Availability of and access to STI and HCT services near where *waria* meet.

The first transgender organization to provide HIV prevention services to *waria* in Jakarta opened in 1998, with the purpose of empowering the transgender community and reducing stigma and discrimination. A founder of the CSO explains: "it's a real pity that my friends got discrimination by community everywhere... transgender are always stigmatized with crime [are targeted by police - the law is used against them rather than to assist them]."

Social Welfare supported the project from the beginning. Activities include vocational training, such as hair and beauty skills, business development skills, catering and tailoring skills. In 2001 they were able to expand their program to include HIV activities with support from USAID.

Of these four components, creating a conducive environment is the key factor that affects and determines the successful implementation of the other three components. The absence of necessary policy support and leadership hamper efforts to implement the program. For example, stigma and discrimination prevent *waria* from accessing needed health services. In addition, contradictory or restrictive policies and regulations can prevent *waria* from accessing prevention materials such as condoms, lubricant, etc. Structural interventions aim to change the social, economic, political, or environmental factors so that the environment supports all components of the HIV program.

Some examples of structural interventions:

- 100% condom policies
- Legal changes to permit needle and syringe programs
- Micro-credit and savings programs to reduce economic dependency of women
- Programs to counter stigma and discrimination
- Enforcement of legal and human rights
- Prosecution of sexual violence
- Community mobilization of key stakeholders

Indonesian Experience

Indonesia's response to HIV has primarily consisted of individual- or group-level interventions directed to MARPs and PLHIV, for example, training MSM how to use condoms and how to negotiate condom use. However, a number of important structural interventions have been implemented in Indonesia:

- 100% condom use policies in a number of commercial sex locations across the nation and for MSM is some massage parlors in certain cities
- Mandatory STI screening for FSW in some locations and MSM in some massage parlors
- Development of policies that permit OST and NSP supervised by *Puskesmas* to be implemented
- Development of an HIV policy for the prison system
- Efforts to mobilize local stakeholder support to prevent sexual transmission between FSW and clients are ongoing in over 60 commercial sex "hotspots" around the country

Some interventions, such as the 100% condom use policy, have had only modest success because implementation has not always included the required complementary structural interventions. Although interventions targeted risk factors for HIV exposure at the individual or group level (for example, condom use and condom supply), other factors of risk and vulnerability at the environmental and structural levels were not addressed. For example, contradictory or restrictive local government policies resulted in police sweeps at massage parlors, etc.

Potential Structural Interventions for HIV Prevention in Indonesia

- **Increase public funding for education** to increase educational attainment of girls as a means of increasing economic opportunity for women and girls
- **Create savings plans and micro-finance mechanisms** for FSW and *waria* to provide economic alternatives to sex work
- **Mass media campaign** to de-stigmatize condom use
- **Create legal "space"** for IDUs participating in needle and syringe programs to carry needles and syringes
- Identify and deploy "**Community Public Opinion Leaders**" at the national, provincial, district and local levels to de-stigmatize MARPs and PLHIV
- **Include price of condoms in the "tariff**" for massage parlor-based sex
- **Enforce rights to health services for ALL Indonesians** under the 2009 Health Law
- **Challenge local bylaws** that restrict waria's ability to carry condoms to protect their health
- **Mobilize local stakeholders** to support HIV prevention and related health services

There is no single blueprint for implementing structural approaches for HIV prevention. Instead, the strategy should be relevant to the particular setting and to the needs of the population

being served. The text box contains examples of potential structural interventions for Indonesia.

Key Resources

USAID SUM Program CD-ROM

- Documentation Report, Volume 1: Cross-Cutting Interventions E. Structural Interventions

7.2 Community Mobilization

1. Scope

For Behavior Change Interventions to be successful, it is important to involve local community members in the location where the intervention is performed. This includes involvement both of key people – usually called stakeholders – and ordinary people alike. The main aim for involving communities is to achieve an environment that is favorable for – and even encouraging of – behavior change. The rationale for community involvement is that:

- The community itself stands to benefit from the program
- Beneficiary groups by themselves usually have a very low bargaining position
- Involvement of local stakeholders can help to ensure acceptance of the program
- Likelihood of program sustainability at the community level increases

In relation to HIV programs, community mobilization can be defined as 'the efforts of all community members at all levels in an area to work together to identify and solve problems, in order to gain community agreement and increase ability for responding to the HIV epidemic'.

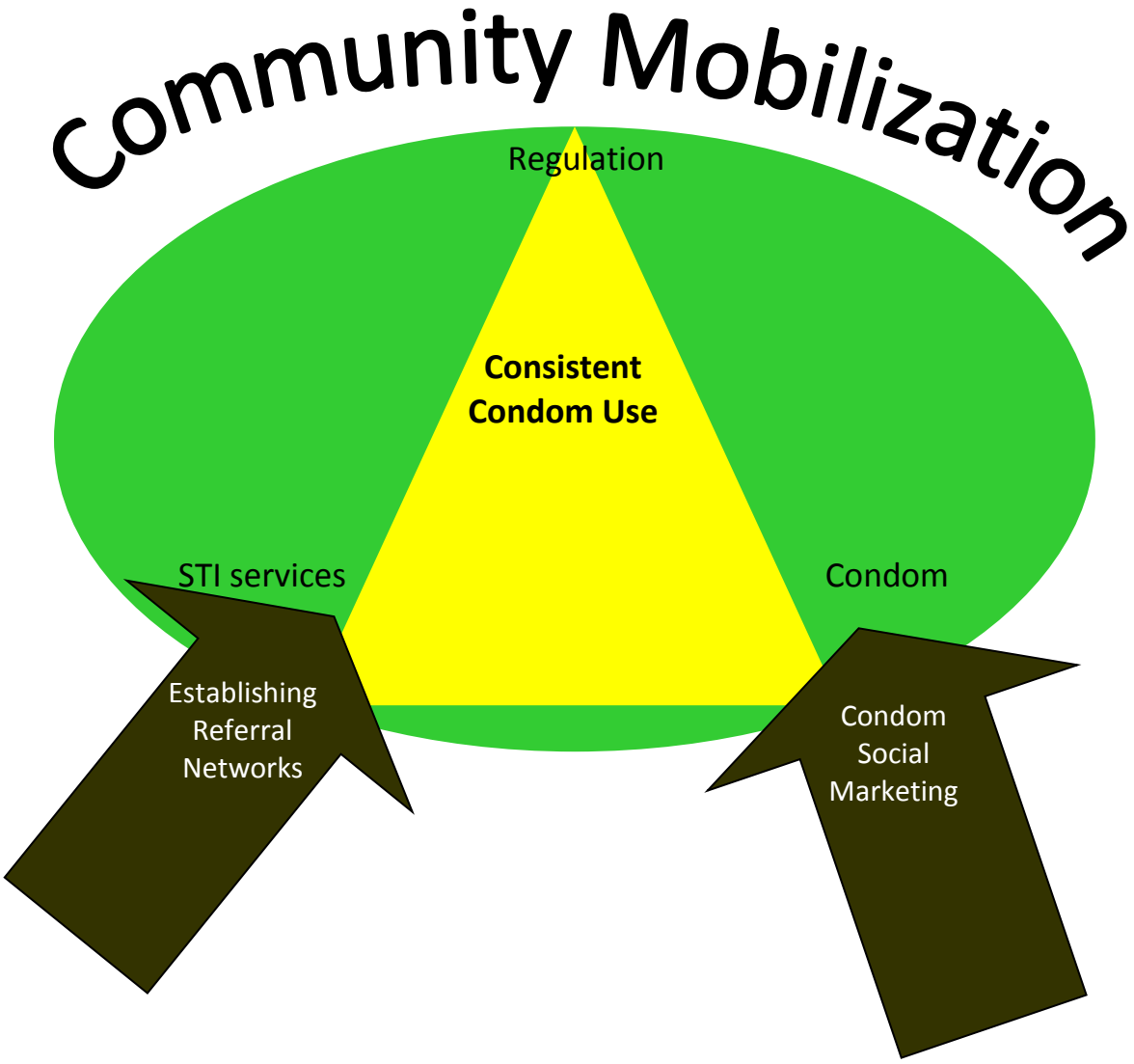
It is important to note that community mobilization is not a stand-alone activity but is a means to ensure a concerted action for four important components in the district response to HIV:

1. Commitment and action by the local stakeholders (and community members), for the application of regulations at the local level, and assurance for their implementation in the field.
2. Condom social marketing to guarantee the availability of condoms for the user.
3. Availability of easy-to-access local health services, especially for STI diagnosis and treatment, and HIV counseling and testing.
4. Involvement of beneficiaries to increase awareness for maintaining their health.

The four important components are interrelated and all are necessary for successful implementation, so that behavior change can happen.

Diagram 5 illustrates the operation of community mobilization. Three key components lay a foundation for achieving consistent condom use among MARPs: 1) regulation, 2) condom availability and 3) STI services. The first requirement addresses a structural intervention, issuing a local regulation that supports consistent condom use for MARPs engaging in risky sexual behavior. The regulation must be endorsed by stakeholders in order to motivate condom use compliance among MARPs. The second requirement is the assurance that the product, price, placement and promotion of condoms are tailored for beneficiaries, their clients and/or partners. The third requirement is the availability, accessibility, and affordability of STI services for the community. All components require the full support of stakeholders and beneficiaries to achieve consistent condom use and safe sex behaviors.

Diagram 5


Community Mobilization
Regulation
Consistent
Condom Use
STI services
Condom
Establishing
Referral
Networks
Condom
Social
Marketing

Involvement of local stakeholders is very important to create an environment conducive to behavior change – both for individual behavior change, and for efforts to transform the social environment where the behavior is going to be applied. Stakeholders and community members should be involved at every stage. They should be approached intensively, and invited to think critically and analyze the problems that they are facing. Only in this way can the sensitivity, awareness and willingness to change from the current situation be triggered. Change is not instant, but is a continual process. The involvement of stakeholders is also important because they live in the area, can participate frequently and are part of the existing system. Behavior change is more possible for beneficiaries if all parties believe in it and support it.

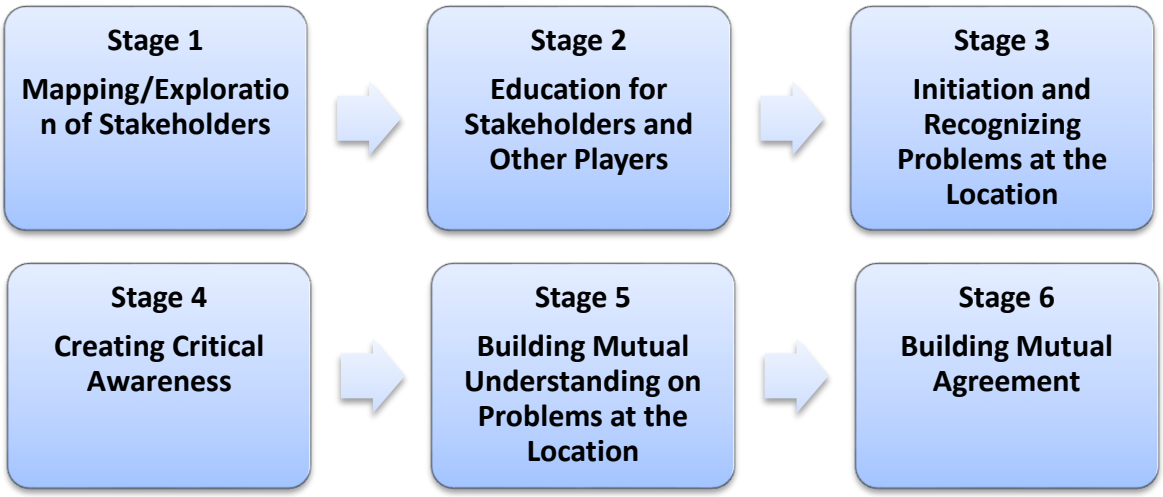
2. Objective

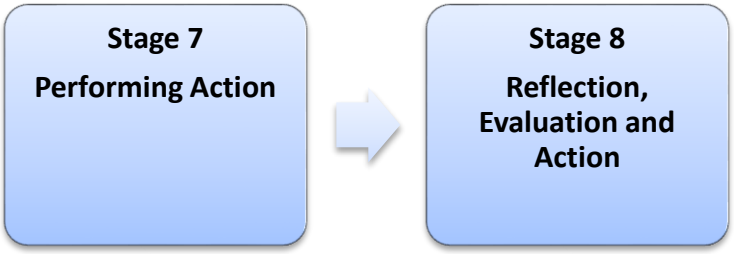
To create an environment conducive for changing risk behavior, both individually and collectively through transformation of the social environment.

Roles of Stakeholders in Behavior Change

In general, MSM behaviors can be affected by people with influence in their immediate environment. The owner/manager of massage parlors can make sure that condoms are available and that condom use is compulsory for sexual transactions for MSW. In hotspots, *preman*, heads of the RW/RT, and/or the senior MSM opinion leader may also influence condom use for MSM in hotspots. Sometimes individual MSM have understood the importance of using condoms for their health, but the massage parlor owner/manager or peers do not realize that condom availability and use are the shared responsibility of all parties in the location. Therefore, interventions should ensure that norm changes in the environment at community level give support for beneficiary behavior change.

3. Stages





Stage 1	Mapping/exploration of the stakeholders and situation at the location
a.	Perform mapping/exploration at the location • Identify who are the key stakeholders in the location: ○ Influential leaders at the location (RW/RT staff, pimp, local security guard) ○ Others (e.g., manager, cashier and security at massage parlors, security at malls, cleaning service, parking attendants, etc.) • Prioritize which stakeholders are key for implementing the HIV program • Mapping/exploration includes: ○ Area: RT (neighborhood), location, village. ○ Demography: education, socio-economic status, age, gender, marital status. ○ Culture: habits, social network ○ Knowledge: how much stakeholders know about STI, HIV, condom use and other related issues, stakeholder current understanding of HIV prevention programs and gaps in their knowledge, their current level of participation in the program and their interest in being more involved in program activities.
b.	Use the mapping and exploration results as a reference for revealing the social structure and network, socio-economic level and knowledge on STI, HIV and other related issues in the location.
c.	Use the mapping and exploration results as a reference to identify the potential key persons for the working group or association in the location. Use the mapping results to plan for stakeholder involvement.
Stage 2	**Education for stakeholders**
a	Improve knowledge and awareness of the stakeholders on STI, HIV and AIDS and how to manage them. • Perform education using well-planned materials and time. • Education can be performed individually (as a part of the outreach) and as a group (such as once a month).

b.	Improve knowledge and awareness of other key players (pimp/manager/owner) on STI, HIV and AIDS as well as how to manage them. • Perform education using well-planned materials and time. • Education can be performed individually (as a part of the outreach) and as a group (such as once a month).
Stage 3	**Initiation and recognizing problems at the location**
a.	Invite the stakeholders and other key players to recognize the STI and HIV problem in the location and relate it with the current problem faced in the location. • Encourage the stakeholders and other key players to plan and perform routine meetings. • Invite the stakeholders to identify problems related to STI and HIV in the location, the risks and consequences for all community members and who are considered as important players/having a role related to the problem. • Describe/explain the positive and negative results of mapping the location including the health, social and economic problems. • Make conclusions from the mapping results and use them for stakeholder recommendation. • Example of conclusion that may appear: Existing location attracts many clients, clients will come and give economic opportunities for local people (pedicab driver/motorcycle taxi driver/small shops).
Stage 4	**Creating critical awareness among stakeholders**
a.	Build awareness and motivation of the stakeholders on the importance of the STI and HIV management efforts at the location. Critical awareness is the first step. • Build critical awareness after the problems at the location are recognized and relate health problems to economic and social problems as well as the potential impact that they might have at the location.
b.	Build awareness that the efforts for managing STI and HIV will become an important factor in the economic level of the local people.
Stage 5	**Building mutual understanding (among stakeholders) of problems at the location**
a.	Build mutual understanding among stakeholders in each meeting and start to spread it to the community.
b.	Next, create awareness that the responsibilities for STI and HIV management efforts are common responsibilities and need initiative and commitment from local stakeholders. • Create awareness that local initiative will be able to run STI and HIV programs longer with their support.
c.	Build awareness and motivation among all community members at the location on

	the importance of STI and HIV management efforts in the location. • After recognizing problems at the location, build awareness on the importance of the STI and HIV management efforts. • Build awareness that the responsibilities for STI and HIV management efforts are shared responsibilities and need initiative and commitment from local stakeholders.
Stage 6	**Building mutual agreement and commitment**
a.	To make the condition and situation well maintained according to the agreed objectives, make a mutual agreement. • Build mutual agreement at the stakeholder level first. • Then, encourage the stakeholders to initiate agreement expansion with all representatives from the community.
b.	Establish a working group (WG) that has commitment to develop and implement STI and HIV management program at the location. • Encourage stakeholders and other community leaders to establish a working group at the location/community level, which has good structure with clear roles and job divisions. • Make sure that the working group is supported by all parties and is recognized with power to move the program forward at the community level.
c.	Workplan development • Develop a specific workplan for a defined time period. • Make a clear role and job distribution for workplan implementation.
Stage 7	**Performing actions**

a.	Mutual awareness and perception among stakeholders is followed by activities in the community:
	• Types of action:
	  ○ Workplan implementation
	  ○ Creating work mechanism for working group
	  ○ Creating communication mechanism in the working group
	  ○ Developing and applying rules at the local level
	• Act gradually and systematically according to the mutual agreement.

b.	Local regulation development • The development of a regulation is started by participatory problem identification with all the groups in the location. • There should be agreement that regulations that are created do not have to be finished at that time. It is possible to add to or reduce regulations as they are developed and when they enforced. • Conduct review and evaluation of regulation implementation. Analyze what works and what does not work.

	• Improve and refine the regulations and then apply them according to the agreement.
Stage 8	**Reflection, evaluation and action**
a.	Create monitoring and evaluation mechanism on the workplan implementation. • Schedule routine monitoring activities according to each respective job. • Every month the activities will be reported to the coordinator. • Every three months, a meeting will be held to discuss the workplan, results of monitoring and plan the next month's activities.
b.	Use the monitoring and evaluation results for doing reflection on the previous workplan and to plan the next activities.

4. Resources, tools and materials

- Location and needs assessment tools
- IEC materials and various types of IEC media for stakeholder education
- Example/draft of community agreement/regulation
- Example/draft of community workplan
- Monitoring and evaluation tools

7.3 Reducing Stigma and Discrimination

Taking on stigma and discrimination is a challenging task. There are many forms of stigma and discrimination, and these can be experienced in many different settings. The following list gives some of these forms and suggestions on how to intervene.

- **Inappropriate fear of contagion**: Focus on attitudes that counteract fear of HIV transmission through casual contact with people living with HIV and those with alternative sexual orientations.

- **Negative judgments about people living with HIV and MSM**: Focus on attitudes that reflect blame, shame, and making moral judgments on MSM or people living with HIV.

- **Enacted stigma or discrimination**: Focus both on interpersonal forms of discrimination (e.g., isolating or teasing MSM or people living with HIV) and institutional forms of discrimination (e.g., being fired from work or denied health care because of HIV or sexual orientation).

- **Compounded stigma**: Focus on perceptions of the association between HIV and certain marginalized groups, such as MSM.

The HORIZON project suggested a number of **potential strategies** for addressing stigma toward PLHIV and MARPs:

1. **Help institutions recognize stigma** It is important for management and health providers to begin by acknowledging that stigma exists in their facilities. Sharing information

Sigma and Discrimination by the Media

One CSO experienced some difficulties with the media, which liked to report stories that expose HIV-positive *waria*. However, the hospital intervened asking the media not to report news about the hospital, while the CSO directly challenged the journalists over this kind of reporting. The CSO's relationship with the hospital helped in the hospital's response to the media.

"The *waria* at [the CSO] try to have coordination meeting with the media to educate them about *waria* and change their view and stop them using *waria* as a commodity to increase the sales of their newspaper."

Stigma and Discrimination by the Family

"Waria come from various family backgrounds; when they come to Surabaya they live like a female but then when they leave to go home they become a male again because here they are more accepted and are freer to perform like that. Many *waria* are not accepted in their family. In such cases, the *waria* CSO has acted as a mediator between a *waria* and her family, if for example, one of the *waria* becomes sick, and wants to go home to her family for help. Once the *waria* is healthy she comes back to Surabaya again."

about levels and types of stigma in institutions was found to help build staff and management support for stigma-reduction activities.

2. **Address social stigma and the environment**
   Develop tailored interventions to protect the interests and wellbeing of both patients and staff. Use a participatory process to develop action plans to address stigma reduction.

3. **Respond to the needs of the stigmatized populations**
   Some MARPs are wary of HIV services because of the stigma attached to accessing care. Combining HIV-related services with other health services could potentially reduce stigma and discrimination.

4. **Use media to show that AIDS has a human face**
   Popular media has been used successfully in a number of countries to challenge stigma and discrimination. Results from community-based programs indicated that individuals with the highest level of exposure to the intervention were significantly less likely to hold stigmatizing attitudes than individuals with less exposure.

5. **Involve people living with HIV in service delivery**
   Involving people with HIV in providing HIV services and in sensitizing other service providers about the realities of their lives, empowers HIV-positive individuals, improves service delivery, and contributes to stigma reduction among health workers and community members.

6. **Engage the community**
   Stigma-reduction strategies in the community, like training youth members as caregivers, had positive effects on attitudes of family members and other community members towards persons living with HIV. Another strategy trained CBO staff, PLHIV and community leaders to recognize stigma, integrate stigma reduction into their routine work and carry out community sensitization and mobilization activities. Community popular opinion leaders have also been used in a variety of settings to convey HIV risk reduction messages, and were found to help reduce the level of HIV-related stigmatizing attitudes.

7. **Expand antiretroviral therapy (ART)**
   Increased access and uptake of ART has had a positive impact on stigmatizing attitudes and behaviors of community members and on internalized stigma among people living with HIV. Increased availability of ART was associated with reductions in stigma as well as increased awareness that becoming infected can happen to anyone and that almost everyone is somehow affected.

Difficulties of living in a 'third space' between male and female

One *waria* explained that she was lucky because her family were accepting and did not discriminate against her. The problems that she encountered were in the community and in the workplace. She was a teacher and was not allowed to teach dressed as a woman. She decided to give up her job and work instead in a beauty salon. When she was 30 she decided she wanted to help others and got involved in the CSO. Now local *waria* see her as a leader.

In 1979, when the CSO was established, they tried to increase acceptance of *waria* as part of the community, and this started to happen since the 1980s. Now she experiences no problems if she goes to shop in the market. However, they sometimes suffer from negative attitudes in the media. "If we behave like other people and join with the community then we might be accepted as normal people. It is unfair because media cover the negative side and not the positive side. *Waria* care for other *waria*; we engage in social activities and we are managing ourselves. Why do the media not show these examples instead of the negative side?"

Sometimes cynical attitudes also come from the community. Religious practice is important for some *waria* so they go to the mosque, to the church and pray but ironically the people do not understand why you must go to the mosque or the church when you are *waria*. "They think I am *waria* and I do not need to practice my religion". Sometimes *waria* are discriminated against by the family and are fatalistic. She tries to motivate friends that even if you are *waria* you are good people, common people and create more positive images of *waria*. "If you are *waria* you don't have to be a prostitute, you can have any work you want". So now some of the people decided to stop selling sex and are supported by the CSO to have small businesses.

Self stigma and discrimination among the *waria* themselves have decreased, as has the stigma of living with HIV.

Families of Waria

A *waria*-led CSO team emphasize that "family is the main problem" yet conversely, the supportive involvement of family is described by the team as the solution to many of the social problems experienced by *waria* in Indonesia. "My experience is a good one," explains one *waria*. "My family have always been accepting and loving of me as a *waria*." But within the group, her family situation remains the exception rather than the rule. The team describes rejection and isolation from many families – case-after-case of *waria* kicked out of the family home or who flee the violence they experience because of their gender identity.

These very young *waria* arrive in Jakarta unprepared for the harsh realities of a big city and then work on the streets, live in slums and, if they are lucky, find themselves connected to a *waria* network with a matriarch who takes care of them. Supportive engagement of family is particularly important when *waria* experience crises and ill health. *Waria* sick with advanced HIV disease or who have been in accidents can find their families uninterested in assisting them. Medical staff who seek consent from family for treatment can find families unprepared to engage. Even after a *waria* has died some families stay away. Others are shocked in to action only after the death of their *waria* family member. In these circumstances they may approach the CSO with questions about their *waria* family member, how they died and there can be much sadness and regret. In other circumstances the CSO may be accused of criminal negligence, of not informing the family while the *waria* was still alive. "When we have cared for their family members and done everything we can it is so upsetting," says one CSO staff.

The involvement and support of family is therapeutic. The CSO staff describes it as "good medicine." So "for the next program we want to make approaches to the family of *waria*," the CSO manager explains. Their aim is to help to "grow support from the family" toward *waria* – because family support is "an investment we cannot buy."

Key Resources

USAID SUM Program CD-ROM

- Documentation Report, Volume 1: Cross-Cutting Interventions 5. Reducing stigma and discrimination

7.4 Human Rights and Gender Issues

The Indonesian police regularly interpret laws concerning sex work as applying to homosexuality and transgenderism, something that is not challenged or corrected by the government. Arbitrary harassment, summary arrest and detention of *waria* and gay men by the police are commonplace occurrences. In Indonesia, MSM and *waria* in particular, tend to assemble in public areas such as parks and roadsides. Often arrests occur in such places on the pretext of being violations of the Public Disturbance Law (International Gay and Lesbian Human Rights Commission, 2007). Abuses include:

- Stigma and discrimination associated with sexual orientation
- MSM face stigma and discrimination from health providers and the broader community

One *waria*-led CSO runs a program called *Transchool*, which provides informal education for young transgender people. The program educates young *waria* to understand their human rights, sexuality, sexual health and the law.

The *waria*-led CSO has become a leader in HIV prevention for *waria* in Jakarta and they have a strong relationship and partnership with the Jakarta Transgender Forum.

Gender issues:

- Heterosexuality is considered the norm in society. In Indonesia marriage and family are important. Alternative sexual orientation is considered deviant. This and the ensuing stigma and discrimination faced by MSM can drive them underground making them difficult to reach for services.
- MSM lifestyle and appearance is not accepted by society and often communities perceive them as hedonistic. Feminized MSM are more vulnerable than their more masculine counterparts.
- Once a family learns of a member's alternative lifestyle, MSM can be victims of violence. Some families are unwilling to accept their sexual orientation and disown them.
- MSM may try to hide their sexuality in the workplace to avoid stigma and discrimination and the possibility of losing their jobs or demotion.

The way out

- An **enabling environment** is needed with policy support to ensure human rights are protected for ALL Indonesians, including MSM. Leadership and enforcement of policy are critical for addressing these violations and ensuring that MSM have the means to protect themselves from HIV.

- **Empowerment**. Factors that limit the choices available to individuals must be addressed to **enhance individual power:**

    - **E**ducation and leadership development
    - **M**edia use and advocacy
    - **P**ublic education and participation

- **O**rganizing associations and unions
- **W**ork training and micro-enterprise
- **E**nabling services and assistance
- **R**ights protection and promotion

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8. Quality Assurance and Quality Improvement (QA/QI)

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8.1 Introduction

CSOs should be developing and strengthening their quality assurance and quality improvement systems on an ongoing basis. The information provided here on quality assurance and quality improvement (QA/QI) is a summary of what is available in the USAID SUM Program *Quality Assurance/Quality Improvement (QA/QI) for Program Implementation Operations Manual.* It highlights the core tools to be used in the implementation of a QA/QI system – operational component, standard operating procedures (SOPs), training module, QA checklists, proxy indicators and programming processes.

At the CSO level, the tools can be used as they are presented or they can be adapted or expanded as necessary to ensure appropriate QA/QI processes are in place.

8.2 QA/QI Program Implementation Initiative

8.2.1 Definition, Objectives and Principles of QA/QI

Quality Assurance (QA) means establishing standards (for example, clinical protocols and guidelines, program and administrative SOPs) as a basis for assessing and monitoring performance against these standards and ensuring that they are consistent and correctly applied. It also includes mechanisms for continuous quality improvement. Results from QA monitoring help assure the continuous quality of an activity and generate ideas for quality improvement.

Quality Improvement (QI) means establishing and using a client-focused, problem-solving approach to test and implement solutions to problems affecting performance quality.

The QA/QI objectives provide:

- A framework to sustain the highest quality HIV prevention, care, support and treatment services.
- A feasible system and set of procedures for continuous monitoring of technical interventions and programming against established standards.
- An agile, priority-driven, problem-solving approach to improving quality and performance of individuals and systems within CSO.

The guiding principles of QA/QI:

1) Clear standards, guidelines, and protocols will be adapted to local conditions.
2) Staff will be empowered to make decisions and teamwork will be encouraged.
3) QA/QI is participatory – engaging partners, clients and communities – in providing feedback on perceived quality of care.

4) QA/QI will build on existing systems and processes where possible.
5) QA/QI will be evidence-informed, using data and other information as the primary basis for decisions.
6) QA/QI will focus effort on key issues that most affect quality.
7) QA/QI will identify and eliminate non-value-added activities, steps, and processes.

8.2.2 QA/QI Model

- ***QA model: Semi-Structured Interview Using Checklist***

Checklists have been developed for each technical intervention to assess adherence to SOPs and/or protocols. CSOs will periodically conduct semi-structured interviews to identify progress and quality of current programs, as well as identify challenges and issues that the team will work together to resolve. Checklists may serve as a basis for subsequent technical assistance. The QA steps are:

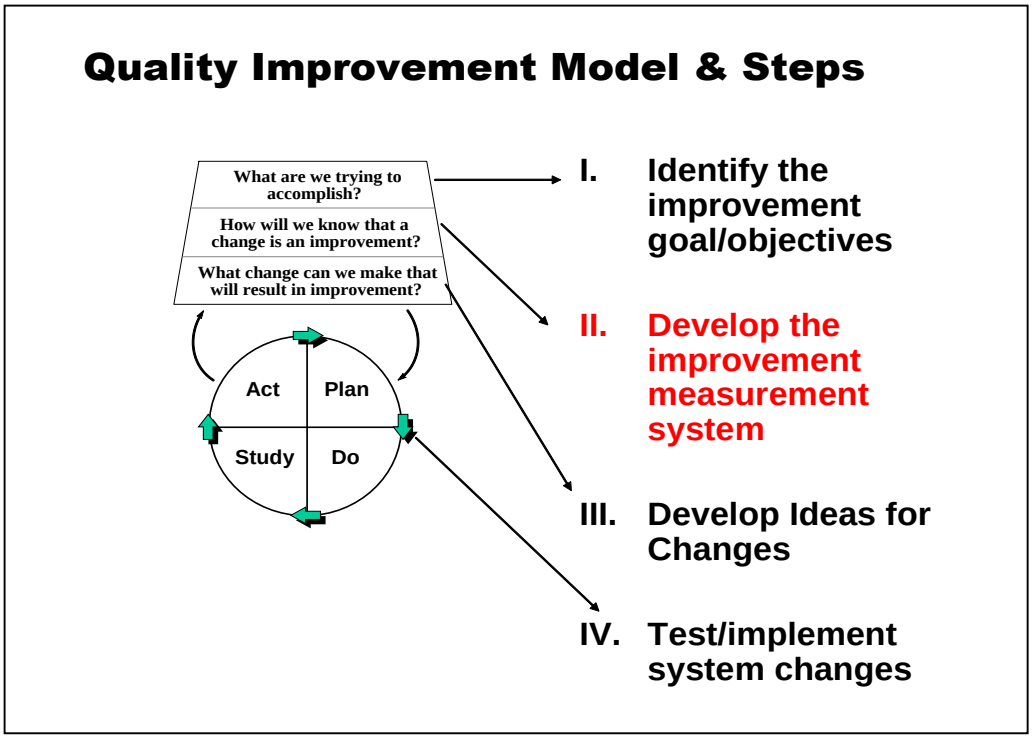
1) Develop standards
2) Implementing standards
3) Measure performance against standards
4) Identify quality gaps and performance issues
5) Address the issues

- ***QI model: Plan Do Study Act (PDSA) Cycle***

The QI model is a method to test, implement and spread change ideas for improving programs. There are three core questions:

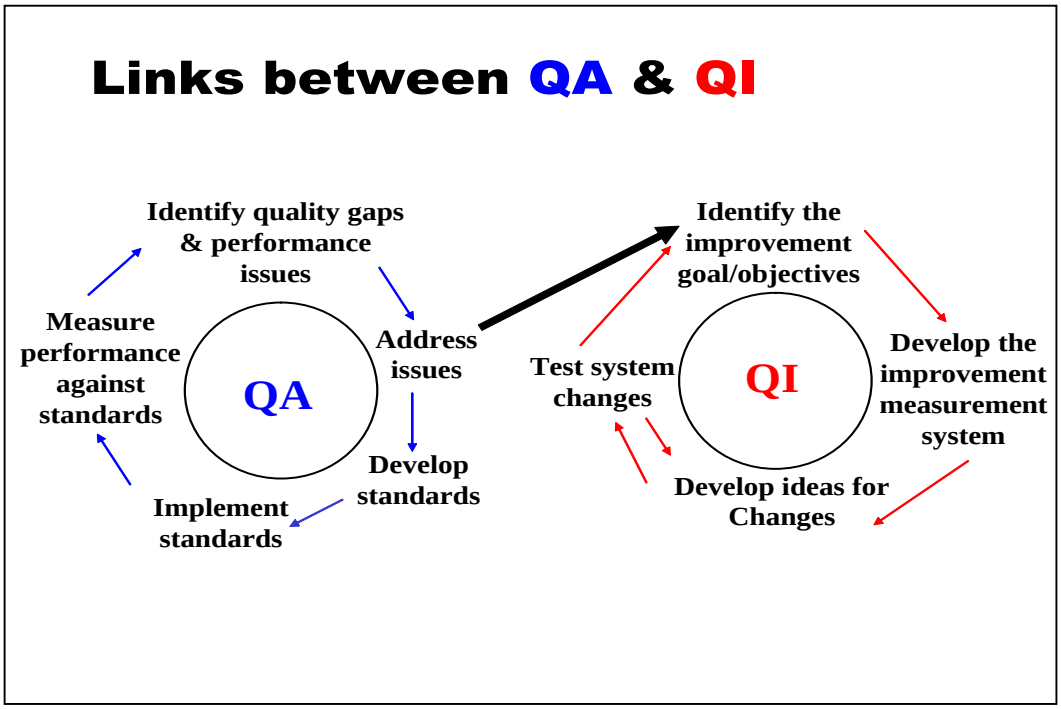
1) What are we trying to accomplish?
2) How will we know that a change is an improvement?
3) What change can we make that will result in improvement?

The chart below explains the PDSA cycle and its implementation steps for improvement.



- ***Links between QA and QI***

Quality assurance and quality improvement are two processes that link together. The links are shown in the following chart.



8.3 How to Implement QA/QI (Operational Component)

1. Define the improvement objective

The improvement objective should be defined. It will help guide definition of proxy indicators. An example for an improvement objective is the percentage of consistent condom use among female sex workers or the percentage of IDUs who use sterile needles.

2. Define proxy indicators for each MARP

The indicators have been developed for each MARP to help CSOs monitor quality improvement by making the run chart. These indicators are already linked to national indicators, which were developed by Ministry of Health.

An indicator is a measurable characteristic of actual system performance that determines the extent to which desired output is achieved, or the degree to which guidelines and standard operating procedures are adhered. Indicators are used to monitor the quality or appropriateness of important activities. It is not necessary to choose an indicator for every standard or specification. The number of indicators should be minimized when assessing key processes and identifying potential problem areas. The proxy indicators are explained further in the M&E section.

3. Design and develop QA tool and method

The QA tools are in the form of a checklist. They have been developed and are in compliance with the standard operating procedures, guidelines and strategies. In using the checklist, CSOs will identify the progress, quality gaps, challenges and performance issues that the team will work together to resolve. Use programming data, information from discussions or interviews, observation, and record review to explore the issues.

4. Develop QA/QI implementation plan for CSO

There are eight steps to developing or improving QA/QI system:

1) Identify/assess current state of CSO QA/QI.

2) If nascent, plan introductory QA/QI training or, if established, consider the need for a refresher.

3) Designate CSO QA/QI staff person or team, and develop a CSO action plan, including timeline to conduct QA/QI. Ongoing quality monitoring should be integrated into all activities and carried out within each activity on a continuous basis. A quarterly or semi-

annual activity review, a structured review of each activity, should be performed on a systematic basis to assess quality using QA/QI tools and checklists.

4) Adapt or, if necessary, revise QA/QI tools to meet minimum standards.

5) Train all CSO and relevant staff in QA/QI tools and processes.

6) Set up monitoring and data collection system.

7) Assign CSO supervisor to conduct internal monitoring visits using checklists and other tools.

8) Based on results of monitoring visits and available indicator data, the CSO QA/QI team develops an improvement plan and a timeline for QA/QI follow up. Discuss periodic reports from the QA/QI activity and indicator data at CSO internal meetings.

Quality Assurance Process

The QA process steps are:

1. Planning for quality assurance
2. Developing guidelines and setting standards
3. Communicating standards and specifications
4. Monitoring quality
5. Identifying problems and selecting opportunities for improvement
6. Defining the problem operationally
7. Choosing a team
8. Analyzing and studying the problem to identify its root causes
9. Developing solutions and actions for improvement
10. Implementing and evaluating quality improvement efforts

8.4 How to Improve Intervention Quality

8.4.1 Define What Quality to be Improved

The QA/QI team will discuss what quality is to be improved; the team will use the QA process (see adjacent text box) to identify and prioritize areas for quality improvement, analyzing or studying the problems to identify the root causes, and developing solutions and actions.

- Programming Technical Quality (Sexual Transmission and IDU). Quality of programming technical performance must be defined in the light of technical standards and guidelines.

- Programming Data Quality. Programming data collected by the CSO. Data on quality are divided into four main subsections:

1) ***Validity****:* all critical issues related to the degree to which existing data systems are able to yield accurate data.

2) ***Reliability****:* all issues related to whether systems are in place to generate quality data consistently.

3) ***System Integrity***: all other systems related to issues that ensure the overall data collection and management system is working well.

4) ***Accuracy***: focusing on the linkage between supporting documentation and indicator outputs by randomly reviewing key performance indicators.

8.4.2 Define Method to Monitor the Proxy Indicators

Method to identify the cause of quality gap using cause and effect analysis

There are two ways to graphically organize ideas for a cause-and-effect analysis. They vary in how potential causes are organized: (a) by category: called a *fishbone diagram* (for its shape) or *Ishikawa diagram* (for the man who invented it), and (b) as a chain of causes: called a *tree diagram*.

Example of Proxy Indicators for MARPs

Main Indicators for Sexual Transmission Interventions

Number of:

- MARP reached (FSW, MSM and Transgender)
- New MARP reached (FSW, MSM and Transgender)
- Contacts in each MARP
- MARP involved in IRA (FSW, MSM and Transgender)
- MARP involved in GRA (FSW, MSM and Transgender)
- IEC materials and condoms distributed in each MARP
- MARP who access STI services (first screening)
- MARP who access VCT services (Pre test and post test)
- MARP who access case management services

Main Indicators for HIV Counseling and Testing

Number of:

- Clients who received the services
- New clients who received the services
- New clients referred by CSOs and who received the services
- Clients who received HIV pre-test counseling
- Clients who received an HIV test
- Clients who received HIV post-test counseling
- Clients who received HIV post-test counseling, and received the result
- Clients for whom the result is positive
- Pregnant women who were tested for HIV and received the result
- Pregnant women for whom the result is positive
- Pregnant women's partners for whom the result is positive
- Positive clients referred to Care, Support and Treatment (CST) Services

Main Indicators for Injecting Drugs User Interventions

Number of:

- IDU reached
- New IDU reached
- Contacts
- IDU who are involved in IRA
- IDU who are involved in GRA
- IDU who accessed NSP services
- Needles distributed
- IDU who accessed VCT services (Pre test and post test)
- IDU who accessed case management services
- Prisoners contacted

Indicators: Care and Support Services

Number of:

- Clients who received the services
- New clients who received the services
- HIV Positive Clients
- Clients who received TB screening
- Clients who are eligible for Antiretroviral Therapy (ART)
- Clients who received the ART until the end of this month (cumulative)
- Clients who newly received the ART in this month
- Clients who reported good adherence

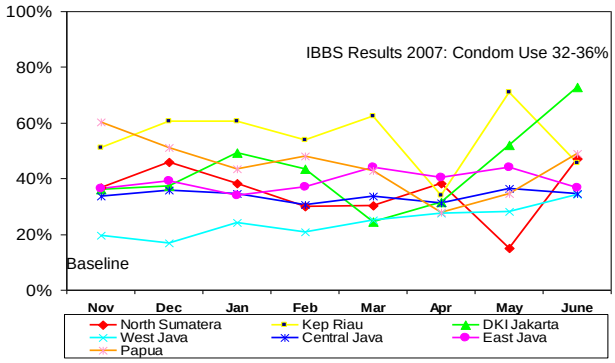
The choice of method depends on the team's need. If the team tends to think of causes only in terms of people, the *fishbone diagram*, organized around categories of cause, will help to broaden their thinking. A *tree diagram*, however, will encourage team members to explore the chain of events or causes

Define planning what CSO Can Do Next

1) Select a priority issue for improvement and gather/collect the data

- Draw a run chart and interpret the data (see example below)
- Use information for improvement

Proporsi FSW yang mendapat layanan IMS dan melaporkan menggunakan kondom saat hubungan seks terakhir
November 2007 – June 2008



2) Develop your quality improvement approach

- Plan assistance from a partner
- Identify improvement objective
- Design an improvement strategy

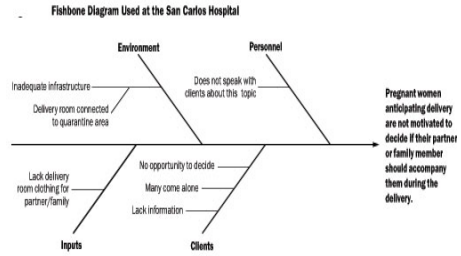
8.4.3 QA/QI Tools for Technical Intervention and Programming

QA/QI tools can be adapted to the needs of CSO. The specific tools formulate technical performance and programming.

QA Tools including Implementation Guidelines:

Fishbone Diagram or Ishikawa Diagram

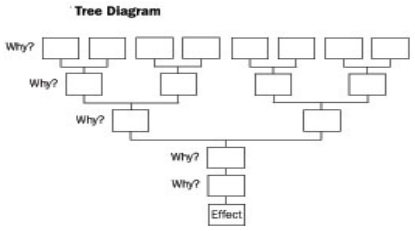
The fishbone diagram helps teams to brainstorm about possible causes of a problem, accumulate existing knowledge about the causal system surrounding that problem, and group causes into general categories



Tree Diagram

The tree diagram starts with the effect and the major groups of causes and then asks for each branch, "Why is this happening? What is causing this?"

The tree diagram is a graphic display of a simpler method known as the *Five Whys.* It displays the layers of causes, looking in-depth for the *root* cause. This tool can be used alone or with any of the cause-and-effect diagrams.



The QA tools consist of:

- Sexual Transmission
- Injecting Drug Users
- Data Quality or Monitoring and Evaluation

QI Tools

To monitor quality improvement, the team will use a QI Plan. It includes the list of issues that will be followed up on, a list of identified problems or weakness, and a list of actions that will be carried out, the timeline for completing actions, and who will follow up on each problem or weakness.

These tools are available in the USAID SUM Program QA/QI manual. See Key Resources text box at end of this section.

Supervision Report

The supervision report will be completed by the QA/QI team after they finished the process. The report should be sent to the CSO program manager or director and other partners who concur with the quality program intervention. The contents of the supervision report describe the intervention situation and technical issues.

Training Curricula for Behavior Change Intervention Package 1 consists of 18 modules:

1. *Policy for Intervention on STI, HIV and AIDS*
2. *Role and Responsibilities of outreach workers/field workers*
3. *Basic Concept on Behaviour Change Intervention*
4. *Rapid Needs Assessment for Developing Behaviour Change Intervention*
5. *Reproductive and Sexual Organs*
6. *Sexually Transmitted Infection*
7. *Sex, Sexuality and Gender*
8. *HIV and AIDS*
9. *Sexual Orientation, Sexual Behaviour and Sexual Identity*
10. *Safe and Risky Behaviour*
11. *Condoms*
12. *Condom Negotiation*
13. *Reproductive and Sexual Health*
14. *Drugs and Alcohol*
15. *Myths and Facts*
16. *Values*
17. *Building Learning Commitment*
18. *Plan of Action*

8.4.4 List of Guidelines, Standard Operating Procedure (SOP) and Training Curricula

All guidelines, SOP and training curricula listed below are available on USAID SUM Program CD-ROM.

Sexual Transmission

1. Guidelines

- BCI Guideline

2. Standard Operating Procedures (SOP)

- Outreach
- Individual Risk Assessment
- Group Risk Assessment
- Peer Education
- Peer Support Group
- Hotline
- Internet Chat – in and out of office
- Edutainment
- Community Based Referral Services
- Local Stakeholders Enforcement
- Condom Distribution Management

Injecting Drug Users

1. Guidelines

- Policy and HIV prevention program for IDU, MoH, 2003
- Advocacy for effective HIV prevention among IDU, MoH, 2003
- Outreach training on HIV prevention among IDU, MoH, 2003
- Rapid Situational Assessment to develop HIV prevention program among IDU, MoH, 2003
- Implementation of Harm Reduction program for narcotics, psychotropic and addictive, MoH, 2006
- Implementation of Harm Reduction program, MoH, 2008
- Strategy on HIV prevention and drug abuse in prison, 2005-2009
- Implementation on monitoring, evaluation and reporting of program implementation, Dirbinsustik, Justice and Human Rights Ministry, 2007
- Implementation of Quality Improvement process, ASA/FHI, 2009
- Implementation of Annual Survey, IDU unit, ASA/FHI, 2009

2. Standard Operating Procedures (SOP)

- Implementation of HIV Care, Support and Treatment Services in Prison, Dirjenpas, Justice and Human Rights Ministry, 2007
- Comprehensive and Integrated Intervention model, HIV prevention intervention among IDU, IDU Unit, ASA/FHI, Jakarta, 2009

- Recording and reporting for outreach daily reporting form, individual risk assessment form, group risk assessment form, group activity form for community and prison and VCT and CM form

3. Training Curricula

- Basic module of outreach for IDU, IDU Unit, ASA/FHI, 2006
- Advanced module on HIV prevention program for IDU, IDU Unit, ASA/FHI, 2007
- Resource module on HIV prevention program for IDU, IDU Unit, ASA/FHI, 2009
- TB module on HIV prevention program for outreach worker, IDU Unit, ASA/FHI, 2008
- Module on HIV prevention program for Field Coordinator, IDU Unit, ASA/FHI, 2008

Voluntary Counseling and Testing for HIV

1. Guidelines

- Voluntary Counseling Testing for Counselor, 2011
- Provider Initiated HIV Testing and Counseling (PITC) for Health Provider, 2010

2. Standard Operating Procedures (SOP)

- Voluntary Counseling Testing for Counselor, ASA/FHI, 2006

3. Training Curricula

- Module on Voluntary Counseling and HIV Testing, Ministry of Health (MoH), 2011
- Module on Provider Initiated HIV Testing and Counseling (PITC), Ministry of Health (MoH), 2010

Care and Support Services

1. Guidelines

- Case Management Services

2. Standard Operating Procedures (SOP)

- Case Management Services, ASA/FHI, 2006

3. Training Curricula

- Basic Module of Case Management Services for Case Manager, ASA/FHI, 2001
- HIV/AIDS Case Management Services, ASA/FHI, 2007

- HIV/AIDS Case Management Services, CST Advance module, Ministry of Health (MoH), 2005
- HIV/AIDS Case Management Services, Advanced module on Psychosocial Support for Rehabilitation, Ministry of Health (MoH), 2008
- Support Group: Positive Prevention for HIV/AIDS Program, ASA/FHI, 2007
- Support Group: Positive Prevention for Outreach Worker, Counselor and Case Manager, ASA/FHI, 2008
- Support Group: Positive Prevention for Support Group, ASA/FHI, 2008
- Support Group: Public Speaking for PLHIV, Bandung Plus Support (BPS) and FHI, 2003
- Counseling for Peer, Bandung Plus Support (BPS) and FHI, 2004
- Home Based Care, ASA/FHI, 2007
- Counseling Adherence, ASA/FHI, 2006
- Counseling Adherence for Counselor, Ministry of Health, 2010

Monitoring and Evaluation

1. Guidelines

- Monitoring and Evaluation Guideline, Ministry of Health, 2009

2. Training Module

- Monitoring and Evaluation Training Module, National AIDS Commission, 2009

Key Resources

USAID SUM Program, *Quality Assurance/Quality Improvement (QA/QI) for Program Implementation Operations Manual*

Note: Guidelines and training materials related to monitoring and evaluation can be accessed on the following websites:

- FHI (www.fhi.org)
- UNAIDS (www.unaids.org)
- WHO (www.who.int)

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9. Monitoring and Evaluation

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9.1 Introduction

In the designing and implementation of HIV programs, M&E is part of the program cycle that consists of planning, implementing, monitoring and evaluating, and then repeating the cycle again.

Monitoring and evaluation (M&E) is an activity to check if the project design is holding true during implementation and through to completion of the operation; and to discover why the design is working well or not in achieving the objectives. Sometimes, these two functions clearly overlap and complement one another. Good monitoring data can be a source for evaluation.

Monitoring is the routine, daily assessment of ongoing activities and progress; it looks at what is being done. Meanwhile, evaluation is the episodic assessment of overall achievements with the aim to determine the relevance and fulfillment of objectives, as well as efficiency, effectiveness, impact and sustainability.

In the M&E process, a CSO should have understanding of the epidemic situation, the HIV prevalence, tracking of implementation and how it correlates to behavior change in order to decrease the HIV prevalence, and use all that information to improve the program design.

9.2 The Importance of M&E for a CSO

Monitoring and evaluation enables a CSO to review its progress and identify successes or failures as early as possible. CSOs use results of monitoring and evaluation to propose action or refine their program strategy in order to achieve a program's objectives.

There are several **questions** to be answered when a CSO undertakes monitoring and evaluation.

1. What information does the CSO need to know?

The information should fit within the program's goal and objectives.

2. *How will the information be collected?*

Formal reporting can be one data source or a specific survey can be used to see impact or program effectiveness.

3. Who will take responsibility for collecting data and analyzing the result?

Program staff should be actively involved in the M&E activities. Program staff should be familiar with the program and know constraints and why things are done the way they are. On the

other hand, it may be difficult for them to find time to stand back and reflect, and look critically at what they have been doing. For this reason, it is sometimes useful for someone from outside the program to be involved, either as the person responsible for carrying out the activity or as a facilitator.

4. How frequently will data collecting happen?

The frequency for collecting monitoring and evaluation data depends on when the organization needs the information on project indicators. Generally, monitoring data is routinely collected on the process of program implementation. For example: information on " the number female sex worker is contacted by outreach worker" is collected after the outreach session is done. Meanwhile, evaluation data may collected before, during and/or at the end of the program.

5. Who should be involved to avoid unintentional bias?

The least powerful, visible, and assertive people should have as much opportunity to be involved as those with more confidence and status. The data collector and the selection of sampling methods are important considerations to avoid bias during the design for data collection methodology.

6. Who uses the result?

As previously stated, the CSO can use the M&E results for improving its program. However, not only the CSO can but also government and donor policy makers, and the end beneficiaries gain benefits from the M&E process.

Policy makers may use the results to assess their program and to know in detail what is going on, the lessons learned, and to make relevant decisions on policies. Donors may use the result to decide whether to start or continue funding, to fulfill their commitment for accountability, and to discover the effect of their policy. Beneficiaries may use the result to understand what is happening to them, to understand the reasons behind decisions that affected them, and to see how they can contribute to improve the effectiveness of the program.

9.3 Developing an M&E System for a CSO

Developing the M&E system should be as simple as possible. Most programs collect more data than they can use. The more complex the M&E system, the more likely it will fail. The M&E system in the organization must include a standardized core approach. If each implementer uses a different system or tools inconsistently, the data cannot be analyzed or summarized effectively. Below are the steps for how a CSO can develop an M&E system for their program.

9.3.1 Create a Logical Pathway of Result

M&E is developed after the program strategy is defined. The M&E person should identify the program goals and objectives, and the main activities needed to achieve them. The M&E person should understand the way the program is being implemented. Creating a logical sequence of results will help make it easier to understand the program and the correlation across goals, objectives and main activities. This logical sequence is also known as the logical pathway of results (UNAIDS 2002).

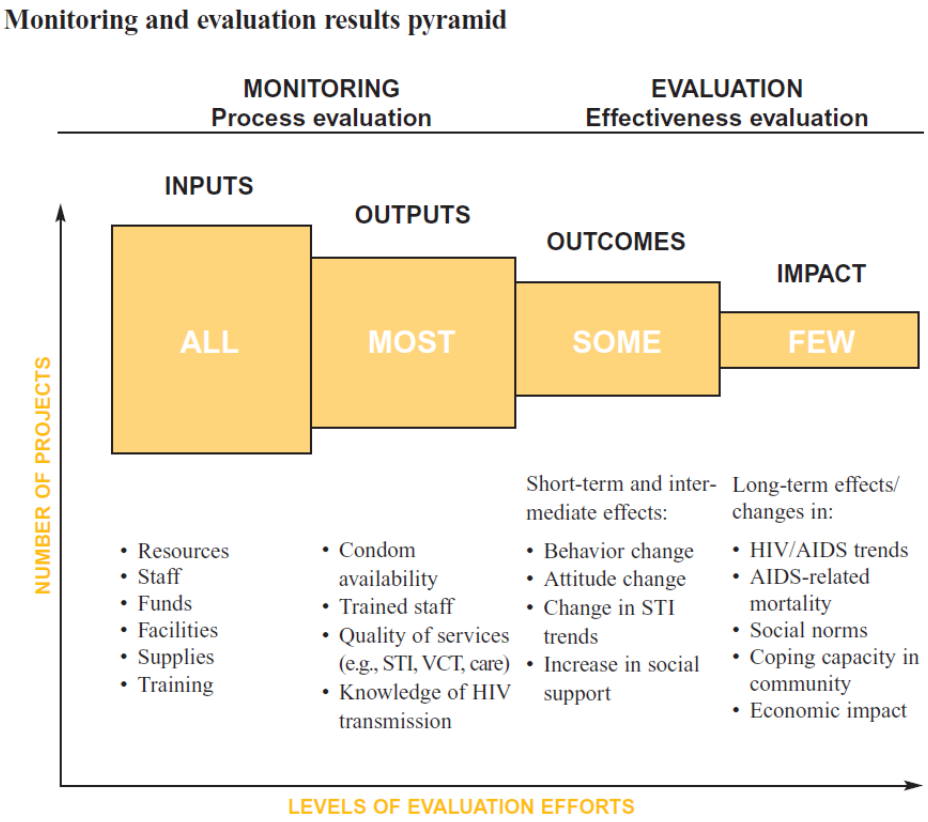

Figure of logical pathway of results

Description of the logical pathway:

- **Inputs**: Inputs are the people, training, equipment and resources that we put into a project, in order to achieve outputs.

- **Outputs:** Outputs are the activities or services we deliver, including HIV prevention, care, support and treatment services, in order to achieve outcomes. The processes associated with service delivery are very important and involve quality, unit costs, access and coverage.

- **Outcomes:** Through the provision of good-quality, economical, accessible, and widespread services, key outcomes should occur. Outcomes are changes in behavior or skills, especially safer HIV prevention practices and increased ability to cope with AIDS.

- **Impacts:** The above-mentioned outcomes are intended to lead to major measurable health impacts, particularly reduced STI/HIV transmission and reduced AIDS impact.

9.3.2 Develop the Indicators

Indicators are the statements – the signs and markers – that help us determine 1) how close to the path we are in achieving program objectives, 2) how the implementation is being conducted as compared with the program plan, and 3) how much things are changing that may lead to improved health status.

Inputs and outputs are data on the direct result of activities implemented (process), for example, condom availability, number of people trained, etc. Outcomes and impact are data on the combination of all the activities, not only implemented by a CSO, but also the combination of activities carried out by stakeholders and organizations in the implemented area.

Indicators

Indicators can be expressed in different ways:

Numeric indicators

- Expressed as counts, percentage, ratios, proportions, rates or averages.
- More informative to use numeric indicators, because they simply say what was achieved. They measure the coverage of the program and the effect on behavior. For example:
  - # clinicians trained in syndromes management of STI in the last 6 months
  - # children provided with psychosocial counseling in the past 3 months
  - % men who have sex with men reporting condom use at last act of anal intercourse

Non-numeric indicators

- Expressed in words (qualitative indicators) and usually denote the presence or absence of an event or criteria. For example:
  - VCT module completed? (yes/no)
  - Local regulation implemented? (yes/no)

- Can also be used to summarize descriptions or assess quality or comprehensiveness, by creating an index of items that can each be assigned a number, which are then totaled to produce a score.

Indicators should be directly related to the project or program objectives. The process of selecting indicators can be fairly straightforward if the program objectives have been presented clearly and in terms that define the quantity, quality, and timeframe of a particular aspect of the program (SMART: Specific, Measureable, Achievable, Reliable, and Time-bound)

When selecting indicators, CSOs can use as a reference HIV program indicators published by international organizations and government (UNAIDS, Global Fund, MoH, etc). To select indicators that are appropriate for the program objectives, there are some rules, which are:

- **Operational:** Should be measurable or quantifiable using tested definitions and reference standards.
- **Reliable:** Should produce the same results when used more than once to measure the same condition or event.
- **Valid:** Should measure the condition or event it is intended to measure.
- **Specific:** Should measure only this condition or event.
- **Sensitive:** Should reflect changes in the state of the condition or event under observation.
- **Affordable:** Should represent reasonable measurement costs.
- **Feasible:** Can be carried out in the proposed data collection system.

9.3.3 Develop the M&E Workplan

The next step after indicators are developed is to create an M&E workplan. It is usually prepared as a table or matrix. It becomes the guideline document for the program implementer on how to conduct M&E. It explains how the indicators will be measured, what kind of data are needed, how to collect and analyze the data, and the resources needed.

9.3.4 Creating Reporting Flows and Formats

A CSO should create flows of reporting. It gives the implementer steps on how data are collected, by whom and by when, and who will be responsible to analyze and disseminate reports.

9.4 Data Collection

9.4.1 Methodology of Data Collection

Data collection is a core component to measure achievement against the program's indicators. The M&E work plan explains data collection methods needed for the indicators. In general, there are two methods:

- Quantitative: Used to collect and analyze numerical data. Population census and survey is an example of the quantitative method.

- Qualitative: Used to collect in-depth information. Usually it explores the "why" or "how" of the situation. Common quantitative methods include focus group discussions (FGD) and in-depth interview.

Quantitative and qualitative methods can be used together. For example, a project may measure the percentage of FSW in a brothel that visit an STI clinic for regular screening, and

finds the number is low, as recorded by the STI clinic. Therefore, to explore why the number is low, the project team does in-depth interviews or FDG with the FSW.

As part of the data collection process, the following should be prepared:

1. Data collection tools and the guideline

Some common monitoring and evaluation tools include:

- Sign-in or registration logs

Every client who enters the facility is required to "sign in." Note: If the clinic provides services that may be associated with stigma (e.g., VCT or STI services), measures should be taken to maintain the confidentiality of the information on the log. Other types of logs may be developed as a way to track program activities on a daily basis. Examples of such forms include counseling, outreach or other activity logs. They are easy to use for recording a set of minimal data; they are inexpensive and efficient (no need to file), and data are easy to retrieve. Registration forms may also be known as enrollment forms or intake forms and generally are used to collect personal (name or ID number) and demographic (e.g., age or sex) information.

- Checklists

Checklists can be used as an aid to observers who are monitoring events, procedures, or services.

- Program activity forms

Program activity forms vary substantially, but are often designed specifically to collect basic information (output indicators) about program activities.

- Tally sheets

Tally sheets are used to compile raw data from logs on a periodic basis. Monthly summary forms are also used to compile raw data from other forms on a periodic basis.

- Open-ended questionnaires

Open-ended questionnaires are often used in qualitative data collection methods as a way to guide an in-depth interview or a focus group discussion to seek descriptive information. Semi-structured questionnaires are often used in quantitative methods as a way to gather information by asking standardized questions in a structured format.

Some data collecting tools have already been developed by the Ministry of Health and other organizations, including PKBI and NU.

2. Train and supervise data collectors

The purpose of training is to ensure that data collectors have the same understanding on how to collect data. Supervision is needed to oversee the data collection, to ensure that the data are good quality.

9.4.2 Maintaining Data Quality

Data quality is important because the *quality of the data determines the usefulness of the results*. There are many ways to ensure data quality. Most of these measures rely on good planning and supervision. The following list gives some ways that programs might ensure good data quality:

1) Developing clear goals, objectives, indicators, and research questions
2) Planning for data collection and analysis
3) Pre-testing methods/tools
4) Training staff in M&E, data collection
5) Creating ownership and belief in data collection among responsible staff
6) Incorporating data quality checks at all stages
7) Ensuring that forms are complete.

9.5 Data Management

Data Management is the process that checks data for completeness and accuracy, as well as data entry, cleaning, and tabulation. After that, it moves to data analysis and interpretation.

1. Completeness and accuracy of data

After the data are collected, the first thing to do is to check the completeness and accuracy of data. Some data may need to be coded in order to simplify the process of organizing the data.

For example, the type of groups targeted for outreached is given a code:

- 1301 is for direct FSW
- 1302 is for indirect FSW

2. Enter data into a computer

Most CSOs have a computer to help their daily work. Computers can help CSOs store and analyze data. Excel is a useful program for simple data management and analysis. Some international organizations and government have developed free software to manage data.

3. Data cleaning

Data cleaning refers to checking for and correcting errors in data entry. In some free software packages, there are systems for checking data entry, which can significantly reduce the amount of time needed for data cleaning.

4. Data analysis

Data analysis is the process of calculating and transforming data based on indicators, for highlighting useful information, suggesting conclusions, and supporting decision making. For example, if you want to know whether your program is on track, you could look at your program targets and compare them to actual program performance. The output of data analysis can be presented in tables or graphics, such as a line chart, bar chart or pie chart.

Key Resources

1. *Kementerian Kesehatan RI Dirjen P2PL. Pedoman Nasional Monitoring dan Evaluasi Program Pengendalian HIV dan AIDS.* 2009
2. *Nahdatul Ulama. Buku Pedoman Petunjuk Teknis Monitoring dan Evaluasi (GF Round 9).* Juli 2010
3. FHI. *Monitoring HIV AIDS Program – A Facilitator Training Guide*. September 2004
4. Global Fund. *Monitoring and Evaluation Toolkit*. Third Edition. February 2009.
5. UNAIDS. *National AIDS Council – Monitoring and Evaluation Operation Manual*. August 2002

5. Data interpretation

Data interpretation means drawing conclusions as a result of data analysis. Interpretation should relate to the goals and objectives of the program.

9.6 Utilization of M&E Results

Disseminating M&E findings and lessons learned can help planning for future activities. It is important to make a plan for disseminating and using M&E findings is important. It should address:

- What information should be distributed?
- Who needs the information?
- How is the information distributed?